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The Canadian Nurse

VOLUME 47 NUMBER 12

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Between Ourselves

Christmas is just around the corner . . . ***Christmas*** — the season of fun and frolic; of parties and packages; of excitement mixed with exaltation. The time of joyous sights and sounds — the one time of the year when all the world wears a smile.

Curiously enough, very similar thoughts regarding Christmas were in the minds of both your editor and **Olive A. Ottaway** as we prepared our material, entirely independently, for this issue. Perhaps these sentiments will guide you, too, at this season.

* * *

Once again a trio of articles from Manitoba provides us with some valuable clinical material. **Dr. J. A. Hildes** and **Dr. P. T. Green** have summed up the essential data of the cause and effect of ***infectious hepatitis*** — a transmissible, systemic disease that may occur in either epidemic or endemic form with fever, chills, malaise, gastrointestinal disturbances and usually jaundice as the distinguishing features. **E. A. Reid** describes the nursing care pattern and **Mona McLeod** points out the environmental factors which seem to favor the spread of this disease — poor sanitation and poor personal hygiene.

* * *

Did you know that petunias and potatoes belong to the same plant family? Did you know that the original name of the carnation was "Coronation" because it was commonly used to make crowns, garlands, and wreaths to be used in the crowning of kings and queens? Or that gardenias absorb water through their petals and leaves rather than through their stems? That is why placing a wet piece of cotton over the flower, then putting them into the refrigerator in the florist's box helps to keep them fresh. **Viola Roberts** has many other interesting suggestions to make regarding ***cut flowers and house plants*** in her article.

* * *

After reading the series of articles on ***hobbies*** published in our August issue, one subscriber has sent us a suggestion that those nurses interested in painting might like to try: "Lay on a background of cobalt or prussian blue (mixed with enough white to tone it down a little) or a grey ground. When complementary colors are used over this ground some startling effects can be obtained. The grey ground produces a misty effect."

* * *

We have been asked by the chairman of the Public Health Nursing Committee, C.N.A., Helen M. Carpenter, to draw our readers' attention to the articles, emanating from the convention of the Canadian Public Health Association, which have been published in their periodical, the *Canadian Journal of Public Health*. There is a series running through three issues on ***The Community Dental Program.*** Last month's issue contained an article entitled "The Role of Public Health Nursing in Case of Attack or Disaster."

* * *

You will be interested to read **Margaret Allemang's** account of how the Belleville General Hospital, Ont., revised and simplified the business of ***recording essential data*** regarding their patients' condition and care. To many nurses the endless round of charting is a positive bugbear. Too often vital information becomes buried in an overgrowth of repetitive phrases — patient slept well — had a good day, etc. What is a "good" day? Doubtless there is room for improvement in the recording that is done in many hospitals. Study this article with care.

* * *

For the past many months we have noted the ***reading time*** for all of the major articles in each issue. The purpose behind this counting of minutes and seconds was not to compete with one of the popular magazines that always notes the reading time but rather to prove a point. We had been told frequently by busy nurses that they simply did not have time to read their own professional journal. Perhaps that was only a weak alibi for not subscribing but we began measuring just how long it would take for a nurse with average speed in reading to peruse material that she really needed to read to keep abreast of developments.

What has the score been? Recently, we added up the recorded reading times from January to September, 1951, inclusive. It works out to a grand total of **12 hours, 13 minutes, 36 seconds.** That covers nine issues — an average of one hour and 21 minutes a month. That rather blows holes in the above-mentioned alibi, does it not? Having conclusively proved our point, we shall discontinue keeping the score after this issue. One of our readers will be glad. She told us the reading time gave her such an inferiority complex — she always took longer than the average !

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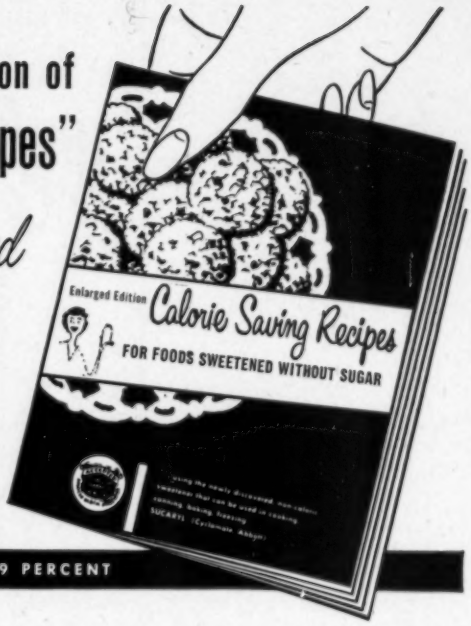

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VOLUME FORTY-SEVEN *NUMBER TWELVE*

MONTREAL, DECEMBER, 1951

The Meaning of Christmas

FOR MANY WEEKS our daily newspapers have been reminding each of us that we have a deadline to meet if we are going to have our Christmas parcels ready in time. So many shopping days left ! As if gifts — buying, giving, receiving them — were all that Christmas should mean to us ! Oh, sure ! It is fun but is that all there is to Christmas ?

On every street in cities, towns, and hamlets mysterious growths of evergreens from tall poles greet us. Stores vie with one another to produce the most original and eye-catching Christmas decorations in their windows. Colored lights are festooned on evergreens in front of our homes, around the doorways, the windows. Some communities stage competitions and award prizes for the gay decorations that most nearly symbolize our conception of Christmas. It is a pleasure on a wintery night to drive through the snowy streets and see them sparkling with red, gold, green, blue lights, brightly colored ribbons, garlands and bright figures. Oh, yes ! It is beautiful but is that all that Christmas means to us ?

Music everywhere. The sweet voices of children singing Christmas carols; the scrape of a bow across strings as the street musician draws a plaintive tune from a protesting violin; the tinkle of her bell as a Salvation Army lass calls to us "keep the pot boiling"; the mooning wail from countless radios as someone yearns for "a white Christmas." Sometimes pleasant, sometimes irritating, there is plenty of music.

What does Christmas mean to us? To the young preliminary student, away from home for the first time, it may mean loneliness. To the intermediate, who has her stint on night duty at that season, it may mean exasperation. There are so many places she would like to go. To the young graduate who, with eyes a-sparkle, watches the gleam of light on her so-important new piece of jewelry, it is a breathless, exciting time. To the head nurse or supervisor there is an element of relief because the patient-load will be lighter. To the patients themselves it is a time of longing for home and loved ones, despite all the kindness the hospital staff may shower upon her.

To each of us Christmas means something different and yet we all may share a common joy in the age-old story of goodwill to men. A poet has given us the clue to the meaning of Christmas:

I shall attend to my errands of love
Early this year.
So that the brief days before Christmas may be
Unhampered and clear
Of the fever of hurry. The breathless rushing that I
Have known in the past
Shall not possess me. I shall be calm in my soul
And ready at last
For Christmas — "The Mass of Christ."
I shall kneel
And call out His name;
I shall take time to watch the beautiful light
Of a candle's flame;
I shall have leisure — I shall go out alone
From my roof and my door;
I shall not miss the silver silence of the stars
As I have before;
And oh! perhaps, if I stand there very still,
And very long
I shall hear what the clamor of living has kept from me —
The angel's song!

To each of you, wherever you may be, the staff at the *Journal* offices sends greetings. May you be blest in a happy Christmas, a friendly Christmas that will leave a warm glow in your heart through the months to come. May the New Year usher in the realization of your dreams.

Merry Christmas — Happy New Year!

Symbols of Christmas

OLIVE A. OTTAWAY

Average reading time — 5 min. 48 sec.

ONCE MORE it is Christmastide, and throughout Christendom we keep the Feast of Christmas — truly a season when homes ties, family memories, and all the pleasant ways of life are remembered and cherished. For once more we pause, for an all too brief period, from the hurly-burly of modern living, so that with hearts attuned we may turn our thoughts to the real meaning of Christmas, and allow the joy and spirit of Christmas to filter through our being.

If, as we have suggested, Christmas is a family time, then perhaps we should try to visualize the nursing profession as a family, with members in every country of the world — many of whom cannot get home for Christmas. But where is "home"? In adult life, is it not in that area where we have been permitted to serve those handicapped with ill health? But for those who have chosen as their profession "the ministry of healing" there must be a deep and everlasting family bond. There is one thing of which they may all be very sure, and that is that from those who keep their hearts open to the real spirit of Christmas, there may flow out to all within that family, no matter where located, such a measure of goodwill and friendliness that they will be conscious of their part in the family life.

Let us ponder for a little on the setting of that first Christmas night. There was much of wonderment and beauty, for a most brilliant star shone

Miss Ottaway is executive secretary of the Toronto Graphic Arts Association.

steadily "over the place where the young Child lay." There was the unusual beauty of that white light that startled the shepherds "keeping watch over their flocks by night." Later, there was the procession of the richly attired "wise men to worship at the manger." So one could go on, redepicting the beauty of that first Christmas, for there is much to fire the imagination with the quiet dignity and simplicity of it all.

Then there are the Symbols of Christmas. When we in Canada celebrate Christmas, how many of us realize that we do so with a collection of traditions gathered from many lands? Those who came here seeking a new world brought with them rich treasures of customs and traditions which, like a beautifully patterned texture, contribute to what is known in this country as a Canadian Christmas. If, for some of us, the element of surprise and wonderment of the Christmas season may have been lost or become a little dimmed, perhaps it is because we have become so accustomed to the symbols associated with the Christmas season that we miss the significance of their meaning.

Space here will not permit many of these symbolic stories but let us take a few of them. There is, for instance, the Christmas tree which has its tradition in Saxony; the Yule log which originated in France; carol singing associated with the early days of England; the Christmas crib from Poland; the celebration of the "Birds Christmas Tree" from Norway — and the candles — well, they have played a very significant part throughout the ages. First used by the Romans to beautify their pageants and court settings, the lighted candle later became associated with spiritual values, signifying the shedding of light on dark places and the lighting of the traveller to a place of safety. Thus it was that candles were placed in the windows to light the coming of the Christ Child on Christmas Eve, symbolizing a light to illuminate the darkness and guide the traveller to safety and to shelter.

Where did Christmas music originate? It is a joint contribution from all lands — from the little town of Bethlehem over which, we are told, the Angels sang their first Christmas carol, to those countries which have given us the great symphonies — symphonies inspired by Christmas enchantment.

What does Christmas symbolize to you? Is it a time of hurried greeting from you to another? Has a certain commercialism of this festive season had a tendency to detract from the real meaning of the most beautiful of celebrations? To those who read these pages, there must be a real sense that, underlying much of the surface celebrations of Christmas, there is a hunger and desire to find and know the true meaning of Christmas — for our pleasure and enjoyment lie in our happy relationship with our fellow men — our ability to work and feel with them, to pass on to them the spirit of understanding.

Is Christmas the children's day, as some would have us believe? Adults are sometimes prone to think so. To some extent this may be true but let us not forget that Christmas is for adults, too, for then it can have its best meaning — the great and best experience of life: *the joy of giving*. As children, our Christmas experience was largely one of receiving; today, as adults, it is one of giving. What do we give? Gifts, time, service and self? Children wait with longing to see what Christmas will bring; adults have all the fun of planning for it. There should be for each of us a joyful anticipation of the pleasure that we are giving to others, for there is a spirit of surprise and wonderment in giving, far beyond any pleasure of receiving.

Let us not forget that it was the birth of the most unselfish Person in the world that gave us our first Christmas Day. Today, after nearly 2,000 years, we will again be celebrating that anniversary in every country throughout the Christian world. Is it strange that unselfishness should receive such homage? That the simple giving to, and for others, should bring such recognition?

When we think of Christmas music and the great symphonies, do we ever

liken this world of mankind to the greatest symphony of all — the Symphony of Life? If so, how do we play our part? Is it with and in the unselfishness of the Christmas Spirit, creating harmony and accord, where otherwise there would be discord? Someone has said:

> The important part of our Symphony of Life is not just that we play the same music, or that we play in the same key — the important aspect is that we play together.

None of us has the right to stop playing because the music does not go to suit us. For the Symphony of Life will only be beautiful when all men, each playing the instrument for which he is suited, all playing the same music and all attuned to the same key, will play together in genuine cooperation and produce the music that will make the life of man beautiful upon earth and be more lovely than a prayer, before the Lord in Heaven.

And so in every land, wherever the ministry of healing reaches out to mankind, may the glow of true Christmas spirit light from within those who minister and, keeping their Christmas candles burning brightly throughout the year, light those travellers, whose strength has failed them, back to play in the Symphony of Life.

Infectious Hepatitis

J. A. Hildes, M.D., M.R.C.P. (Lond.), F.R.C.P. (C) *and*
P. T. Green, B.A., M.D.

Average reading time — 15 min. 12 sec.

Introduction

Hepatitis is an inflammation of the liver that tends to involve the liver diffusely. It is most commonly due to a virus infection and is, therefore, called infectious hepatitis. It can affect any age group and can present difficult diagnostic problems. Most commonly, however, it affects children and young adults.

The purpose of this paper is to sketch briefly some of the features of this disease, setting it against a background of liver anatomy and physiology and pointing out some of the characteristics by which it can be distinguished from other diseases.

Dr. Hildes is assistant professor in the Department of Physiology and Medical Research, University of Manitoba, and assistant physician, Winnipeg General Hospital.

Dr. Green is lecturer in the Department of Medicine, University of Manitoba, associate director of laboratories, Deer Lodge Veterans Hospital, and physician, St. Boniface Hospital.

The liver is a large and important gland that occupies a controlling position in body metabolism. Therefore liver disease tends to produce signs and symptoms of disturbed metabolism. In order to understand how these signs and symptoms are produced it is necessary to know something of the anatomy and physiology of the liver.

Anatomy

The liver is a large organ, weighing about three pounds in the average-sized adult. It is situated mainly in the right upper abdomen but extends across the mid-line to the left upper abdomen as well. It has a double blood supply. Arterial blood reaches it through the hepatic artery. It also receives, through the portal vein, venous blood from the intestines, stomach, pancreas, and spleen. Thus blood coming from the organs of digestion must first pass through the liver. All blood reaching the liver eventually enters the hepatic veins and soon empties into the heart.

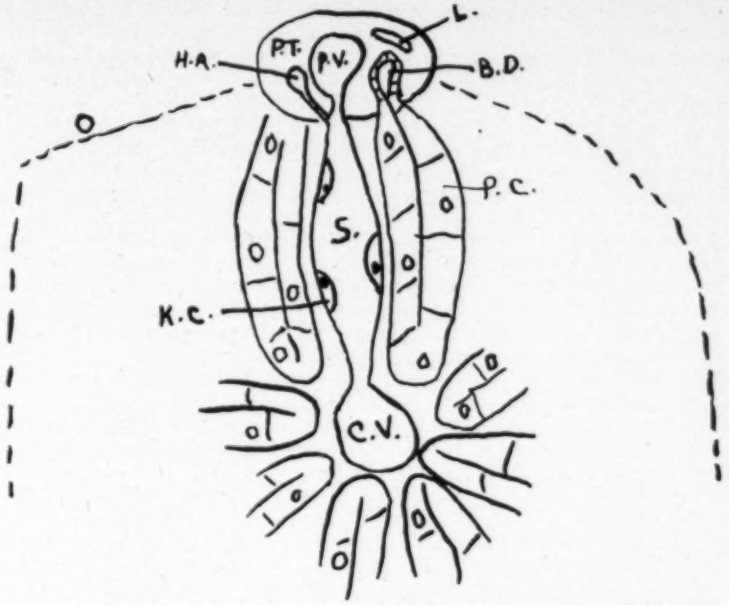

Fig. 1—Diagram of part of a liver lobule showing:

C.V. — central vein	P.T. — portal tract
P.V. — portal venule	P.C. — parenchymal cell
H.A. — hepatic arteriole	K.C. — Kupffer cells
B.D. — small bile duct	S — sinusoid
L — lymphatic	O — outline of lobule

The microscopic arrangement of the liver is important to our purpose. The glandular or *parenchymal* cells which make up most of the liver are formed into *lobules*. The lobules are separated from each other by a fine meshwork of blood vessels. The arrangement is best shown diagrammatically (*Fig. 1*). This, of course, is only a two-dimensional representation and it must be remembered that there is depth to the lobule as well. However, it can be seen that at the centre of the lobule there is the central vein, which collects the blood flowing into the lobule and eventually carries it into the hepatic veins. Radiating from the central vein, like spokes in a wheel, are columns of the parenchymal cells. Blood entering the lobule does so at the "corners" of the lobule, and this blood, which is a mixture of blood from the hepatic artery and portal vein, flows past the columns of liver cells to reach the central vein. Thus the liver cells are bathed in this blood and can extract or add various materials to it.

There is another system of small ducts which carry the bile. The bile is secreted by the liver cells and then flows towards the "corners" of the liver lobule, in bile ductules. These join other small ducts and eventually form the large bile ducts which convey the bile into the duodenum. The gallbladder is an off-shoot of the large bile ducts.

Thus in the "corners" of the lobules we have a collection of small vessels which carry hepatic arterial blood, portal venous blood, bile. In addition, there are also lymphatic vessels. These collections are called *portal tracts*.

The channels that convey blood from the portal tracts to the central vein past the liver parenchymal cells are called *sinusoids*. In the walls of these sinusoids there are cells which

tend to remove particulate matter out of the blood and hence are called phagocytic cells. These cells have been called *Kupffer cells* after the man who described them.

Physiology

The liver is an organ that has many functions. Some of these must be considered now, as they are important for an understanding of the signs and symptoms of liver disease.

1. ***Excretory function:*** One important function of the liver is to secrete bile into the intestinal tract. The bile contains substances, such as the bile acids, which are important in the digestion and absorption of fats from the intestine. The bile also contains bile pigments which are responsible for its green color. These pigments are formed from hemoglobin, the pigment of the red cells. As red blood cells become worn out, they are broken down in the body. The iron and protein in the hemoglobin is saved by the body and used again to form hemoglobin. The rest of the hemoglobin, however, is changed into the bile pigments.

These have no known place in body function and are taken out of the blood by the liver and secreted into the bile. However, they are important in medicine, because if there is any obstruction to the flow of bile, if the liver cells are damaged so that they cannot remove the pigment fast enough from the blood, or if there is a greatly increased rate of red blood cell destruction, the amount of bile pigment in the blood rises, and eventually colors the skin and the sclera of the eyes. We recognize this as jaundice.

If the level of the bile pigment in the blood is high enough, some escapes into the urine and darkens it. The bile pigment in the intestine is changed to another pigment, called *urobilinogen;* some of this is absorbed from the intestine and again excreted into the bile by the liver. However, if the liver cells are damaged they are unable to remove it quickly and it, too, escapes into the urine. In the intestine this pigment is further changed to *urobilin* which is dark brown in color and is responsible for the normal brown color of the stool. However, bile pigment must reach the intestine before urobilinogen can be formed. When bile pigment does not reach the intestine the stool loses this color and is pale or "clay colored" in appearance.

Other substances, such as cholesterol, alkaline phosphatase, and certain test dyes such as bromsulphalein, are also excreted into the bile by the liver. When the liver cells are damaged or when the flow of bile is obstructed the concentration of these substances in the blood tends to increase.

2. ***Metabolic functions:*** Carbohydrates, fats, and proteins are metabolized in the liver but the various products formed during this metabolism are either stored in the liver cells or are returned to the blood and do not enter the bile. These functions are particularly likely to be affected when the liver cells are injured and are, therefore, useful in differentiating between jaundice that is due to obstruction to the flow of bile (as can occur with a stone in the common bile duct or with a cancer blocking the bile duct) and from jaundice due to damage to liver cells. Certain laboratory tests are used to determine whether these metabolic functions are affected.

Galactose is a sugar that is broken down in the liver. A galactose tolerance test is used to see if the liver cells are functioning normally. If they are, then the galactose is quickly broken down whereas, if they are not, the galactose does not disappear so quickly from the blood.

The liver cells convert benzoic acid to hippuric acid. If benzoic acid is fed or injected into a normal subject most of it soon appears in the urine as hippuric acid. If there is liver cell damage, however, it does not appear so quickly. Thus the hippuric acid test can be used as a test of liver cell damage. Incidentally, certain drugs such as morphine and sodium amytal are destroyed in the liver. If there is liver cell damage, ordinary doses of these drugs may produce much greater effects and may be dangerous.

The liver plays an important role in the manufacture of plasma proteins and in the presence of liver cell damage these are usually altered. Many tests of liver cell damage are based on these changes. The cephalin cholesterol flocculation test, the thymol turbidity and thymol flocculation tests and many others are often used. These tests tend to become positive where there is liver cell damage, whereas they tend to remain normal in the presence of jaundice due to biliary obstruction. Prothrombin is another protein which is apparently produced by the liver. In the presence of liver cell damage blood prothrombin is decreased. Vitamin K is required for the manufacture of prothrombin and in obstructive jaundice this vitamin may not be absorbed from the intestinal tract. Thus a low prothrombin activity may be found in plasma. However, if the vitamin is injected the prothrombin returns to normal in obstructive jaundice but does not where there is liver cell damage.

In addition to the functions mentioned above, the liver has important parts to play in the metabolism of various hormones and other substances. Clinical manifestations of deranged metabolism of these substances may appear in hepatitis, in which the liver cells are injured.

The liver, however, is such a large organ and has such a large reserve capacity that in mild cases of hepatitis enough cells are still functioning to maintain adequately most functions within normal limits. In these cases the various liver tests may not show very much abnormality.

Clinical Features of Hepatitis

There are, of course, other causes of liver damage besides the infectious ones. Certain poisons, such as chloroform or carbon tetrachloride, can produce hepatitis. However, we are concerned with the picture produced in infectious hepatitis.

Onset: Being an infectious disease, the onset is often much like that of most infectious diseases. There may be a history of contact with a case of infectious hepatitis about two weeks beforehand. Then the patient develops symptoms which he often calls flu — malaise, slight fever, general aching, loss of appetite, and perhaps nausea and vomiting. He may notice aching pain in the right upper abdomen or in the epigastrium. As a rule the fever lasts a day or so and then the patient feels somewhat better but certainly not completely well. Appetite is still poor and nausea may persist. He feels fatigued and tires very easily. The aching pain may persist. Some cases may show these symptoms for a few days and then gradually recover. The true nature of this illness may never be recognized. However, most cases progress further and develop jaundice. They generally notice that their urine is becoming dark in color like "strong tea." They may notice that their stools are much lighter in color. Then, as a rule, friends notice that their eyes are yellow and that their skin has also changed its hue.

This onset is rather different from the onset of jaundice in obstruction of the common duct due to a cancer, where the jaundice is often the first symptom although it may be preceded by loss of weight. It also differs from the jaundice of gallstone obstruction, which is generally ushered in by severe gallstone colic. However, there is enough overlap in the onset of these diseases to present diagnostic difficulties at times.

Past history: History of contact with jaundice cases may be found in the recent activities of the patient. It is important to inquire whether or not he had any injections, transfusions, or inoculations within the preceding four to five months. There is one strain of the hepatitis virus that is only transmitted by the injection of serum or plasma from other humans who harbor the virus.

A past history of attacks of colic would suggest that the jaundice is most likely due to gallstones. Thus much information may be obtained from the recent history that is helpful in diagnosis.

Physical examination: There are many points in the examination of the patient that may be helpful — the presence of an enlarged, tender liver, a palpable spleen; the presence of certain peculiar spots on the skin (called spider nevi) and other findings would strongly indicate

hepatitis. The presence of a palpable gallbladder would strongly suggest obstructive jaundice.

Laboratory tests: It is well to have a few simple laboratory tests that one can do in cases of jaundice. Even though the clinical features of the illness made one almost certain of the diagnosis, laboratory confirmation is often useful. If laboratory evidence is against the clinical impression of hepatitis — for example, if excretory function is very abnormal but the metabolic functions are normal or only slightly abnormal — this does not mean that the clinical impression is wrong. However, it will make one carefully re-examine the facts of the case. In certain cases, where the diagnosis is undecided after careful clinical appraisal of the patient, rather complete laboratory investigation may be required in order to be more certain of the nature of the illness. Laboratory tests may bring to light the nature of the illness in those mild cases where jaundice is slight or absent.

The importance of diagnosis: It is very important to differentiate between liver cell damage and bile duct obstruction as causes of jaundice because the treatment of obstruction is primarily surgical, whereas the treatment of hepatitis is medical and surgery may endanger the life of the patient. The medical management of hepatitis is dealt with in the next article.

The course of hepatitis: Rare cases run a very severe course, in which the liver cells are almost completely destroyed and death occurs within a matter of a few days. In other cases, particularly those in which the patients remain ambulatory, the disease may become chronic. The jaundice may persist or it may fade but other clinical and laboratory evidence of the disease may persist. These patients may eventually recover completely or they may develop the picture of cirrhosis of the liver.

By and large this is a benign disease and the majority of those who contract it recover completely. It must be remembered, however, that the rare case does not run quite so benign a course. For this reason, and also because it must be differentiated from obstructive jaundice, hepatitis is a disease worthy of the attention of both nurses and doctors.

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Interested in Marriage?

Higher education seemingly hinders rather than helps a girl's chances for romance that leads to matrimony. Among women of 35 to 44 with less than seven years of schooling, almost 95 per cent have been married at one time or other, according to Metropolitan Life Insurance Co. statisticians, whereas among those with more schooling the proportion married declines to 90 per cent for high school graduates and to 83 per cent for those with at least one year of college. Girls with higher education who do marry acquire husbands with more schooling.

The statisticians also show that: On this continent wives are relatively young — two-fifths are under 35 years of age and only one-sixth over 55. In three-fourths of all families the wife is somewhat younger than her husband. In only one family in eight is she older than her spouse and then generally by a small margin. In the remaining eighth of the families, husband and wife are the same age.

About two out of every three of these women were employed at some time before they were married and many continue to work after marriage until the first baby comes. Almost one-half of all wives are employed through the first year of marriage, as against less than one in five at the time of the fifth wedding anniversary.

Currently, the odds are two to one that the wife will outlive her husband.

The Nursing Care of Hepatitis

E. A. Reid

Average reading time — 7 min. 48 sec.

Since the management of hepatitis is largely a matter of nursing care, it is considered worthwhile to outline some of the important aspects of treatment and the principles underlying them. Hepatitis is a relatively common disease and there is evidence that it has been increasing for the past two decades.[1] Most cases resolve spontaneously and leave no apparent sequelae. Therefore the disease is often considered lightly. However, in recent years clinical studies of this disease, particularly those stimulated by wartime epidemics, have indicated that some cases do not completely recover or do so very slowly and that the course of the disease may be influenced by treatment.[6]

Principles of Treatment

Although hepatitis is an infectious disease, no specific therapy against the causative agent — a virus — has been found. Treatment is directed towards ensuring every possible chance of spontaneous recovery. The liver cells are damaged by the infection but, when the acute episode is over, they regenerate. To allow the liver to recover normally, as little work should be asked of it as possible. Thus, bed rest is one of the cardinal forms of treatment.[6] Diet is also most important to provide the necessary nutrients for the regeneration of affected liver cells and to provide calories for the patient in the face of a decreased appetite.

In addition, there are some "negatives" in the treatment of this disease. The liver is damaged and is unable to function normally. Drugs that may be harmful to the liver, such as alcohol and volatile anesthetics, are best avoided.[2]

Miss Reid is a head nurse at the Winnipeg General Hospital.

Some of the more important of these principles of therapy will now be discussed in some detail with particular emphasis on the part played by the nurse.

Bed Rest

Lichtman states that complete bed rest reduces the functional demands upon the liver. Conversely, early ambulation lengthens the clinical course and may aggravate the severity of the symptoms. The principle of bed rest is generally recognized [2,6] but the degree of activity is a matter of some disagreement. Some consider bed rest essential until fever and malaise have disappeared.[2] Lichtman considers that the patient should be confined to bed until all liver function tests are normal. It is suggested as a general rule that the patient should be in bed at least until there is definite evidence that the jaundice is receding. Of course some discretion must be used, taking into consideration the severity of the patient's illness. He may wash and feed himself and, if he feels well enough, may be allowed bathroom privileges. However, the patient must be impressed with the importance of rest even after the malaise and anorexia have subsided and he feels quite well.

Diet

Diet is an important consideration in treatment. As in any other febrile disease it is important that sufficient food be ingested and metabolized to maintain the nutrition of the body. In this connection hepatitis poses special problems. The patient is usually anorexic, if not vomiting, in the early stages and, therefore, he will not eat of his own accord. This phase of vomiting and anorexia may last for several days or even weeks.[6] It is important to maintain the body's nutrition, particularly as the liver is one of

the main organs involved in the metabolism of food. The regeneration of liver tissue during recovery requires amino acids, most readily available from animal protein.

It is said that carbohydrate protects against liver cell damage and should be given abundantly.[2] Formerly, diets for hepatitis, as well as other liver disease, were low in fat. More recent studies indicate that fat is not harmful in this disease.[6] There is no evidence that fats in normal amounts cannot be utilized by patients with hepatitis. In fact, due to the high caloric content, fat may be useful in these cases, provided it can be given in a form which is pleasing to the patient. Therefore, the diet should be high in caloric content, approximately 3,000 calories, of which 400-500 grams should be carbohydrates, 70-100 grams fat, and 150 grams protein.

The diet should be simple, attractive, and palatable. Every effort should be made by the nurse to tempt the patient's appetite. Small frequent servings are best tolerated by the anorexic patient and one must take into account his likes and dislikes.

Dietary Supplements

If the caloric intake is too low it can be supplemented by intravenous glucose and amino acids given slowly.[6] Deficiencies of certain essential amino acids (choline or methionine) have been shown to cause severe liver injury in animals.[7] On this basis some doctors give methionine and choline in doses of 1-5 grams daily to patients with hepatitis. This is a controversial matter as some physicians maintain that additional quantities of these amino acids make no difference to the patient's progress, provided the diet has a normal amount of protein.[6]

Vitamin K is sometimes useful in controlling the hemorrhagic tendency present in some cases of jaundice. This is usually given by injection to patients with a prolonged prothrombin time.

Drugs

Aureomycin in epidemic hepatitis has little effect on the length and severity of the symptoms[8] but certain manifestations of the disease (coma) may be controlled to some extent by this drug.[3]

Certain sedative drugs are normally detoxified in the liver and so may be dangerous in cases of liver disease. This applies to morphine and some of the barbiturates. If sedatives are required chloral hydrate or phenobarbital may be given.[2]

Cortisone appears to be only palliative in the treatment of hepatitis and does not, by exerting a temporary beneficial action, lead to permanent healing. It does, however, produce a marked improvement in the appetite.[4]

Conclusion

The above discussion of the treatment of hepatitis illustrates the importance of careful nursing care in the management of this disease.

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Nutritionists consider that the average person requires 12 milligrams of iron daily. Good supplies of iron may be found in one cup of prune juice (4.3 milligrams); egg-and-tomato salad (2.5 mgm.); two peaches (1.2 mgm.), and two slices of whole-wheat bread (1 mgm.). One serving of pork liver contains the whole day's iron ration.

The Role of the Public Health Nurse in the Control of Infectious Hepatitis

MONA MCLEOD

Average reading time — 10 min. 24 sec

INTRODUCTION

INFECTIOUS HEPATITIS, as a public health problem, has become more significant since World War II when it occurred in serious epidemic form among the troops.

Studies were made of the disease and the environmental conditions which seemed to favor its spread. As a result of the reports which have appeared in public health and medical literature we have become more alert to signs and symptoms which may lead to a diagnosis of infectious hepatitis in the civilian community.

EPIDEMIOLOGY

Infectious hepatitis is caused by a specific virus or viruses, relatively resistant to heat. It occurs in endemic and epidemic forms all over the world. The seasonal incidence seems to be late fall, winter, and early spring; children and adult groups are affected. There are records of babies and very young children being infected but, fortunately, these cases are rare as the outcome is often fatal.

Infectious hepatitis and serum hepatitis, the two types of hepatitis that are communicable, are very similar in their clinical and laboratory manifestations. The chief differences are in the incubation period and the modes of transmission. The incubation period of infectious hepatitis appears to be two to six weeks, while the incubation period of serum hepatitis varies from 30 to 120 days.

The mode of transmission in infectious hepatitis appears to be through the upper respiratory tract and the gastrointestinal tract. Persons carry the causative agent in the blood during the long incubation period and in subclinical cases. Although no definite conclusions have been reached, some authorities state an attack of the disease may give the individual immunity for a short time — perhaps six months to a year. Studies done in large army camps during World War II showed serum hepatitis, otherwise known as homologous serum jaundice, could be transmitted through parenteral inoculation of human blood or its products. Factors contributing to the spread of the disease in a community are poor sanitation and poor habits of personal hygiene. It may at times be fly-borne.

There is usually a prodromal period of five to ten days preceding the appearance of jaundice. The prodromal symptoms include marked anorexia, lassitude, nausea and vomiting, severe headache, fever, chills, muscle pains, and abdominal tenderness. These symptoms vary in kind, number and degree but anorexia is almost always present. Dark urine and light-colored stools are usually noticed before jaundice appears. Some patients do not develop jaundice but have the other symptoms. In an army camp where an epidemic of infectious hepatitis was in progress these cases were given treatment. However, in a civilian population such cases could easily be overlooked resulting in further spread of the disease. Relapses and chronic hepatitis may occur due to lack of adequate care.

The jaundice stage appears five to ten days after the first symptoms and commonly clears in 10 to 14 days. However, it has been known to persist for more than six months. The average person recovers from infectious hepatitis in four to ten weeks.

PUBLIC HEALTH FUNCTIONS

The public health nurse's concern

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in an epidemic of infectious hepatitis would be finding known cases, undiagnosed cases, and subclinical cases, and getting all under medical treatment, as well as giving nursing care and instructing families in the care of the patient and prevention and control of the disease.

It is important for the public health nurse to help the mother to understand the nutritional needs of the child or adult who is sick in the home. The diet should be high in proteins, minerals, and vitamins. As appetite improves, carbohydrates and fats are added.

The mother may need help in planning suitable occupations and play during the long convalescent period for children of preschool and school age.

An Example of a Small Epidemic

A case of infectious hepatitis occurred in a small rural community of about 150 people situated 40 miles from a large city. Many of the men work in the city and commute daily. The economic level is low, homes are small and crowded. Sanitation is poor, outdoor toilets are the rule and the majority of homes are dependent upon wells and rainfall for their water supply for the household.

Infectious hepatitis occurred in the Amos family, which consisted of the father, mother and two children — Mary, aged 10 years, and Jane, six years.

Mary became ill in the latter part of August; she had symptoms of anorexia and lassitude at first. Nausea, vomiting, and elevated temperature developed about two days later. Mrs. Amos was not alarmed since Mary had similar symptoms with the 'flu and upset stomach. She was put to bed until these symptoms lessened. Then she was allowed to get out of bed. Anorexia and lassitude continued and there was some tenderness over the abdomen. Jaundice appeared on the sixth day and lasted for approximately two weeks. Mrs. Amos called the public health nurse when the jaundice appeared. Mary's temperature was 99° F. Her mother stated she would not touch food.

Mary was put back to bed since complete bed rest is the most important part of the treatment. A bed-bath was given to stimulate circulation and promote better rest. It was suggested to Mrs. Amos that she offer Mary frequent small meals in order to stimulate her appetite. Milk, eggs, and fruit juices, with their high protein, mineral, and vitamin content, could be made up into drinks, eggnogs, and milk soups until Mary's appetite improved. Then additional protein and carbohydrates, in the form of meat and vegetables, could be offered to her. Beef is considered one of the best sources of protein and minerals for patients with infectious hepatitis.

The mode of transmission and the importance of personal hygiene were discussed; particularly the washing of the patient's hands and those of the attendant. Discharges from nose and mouth should be taken care of by the use of tissues or rags which can be burned. Careful disposal of feces and urine is important. Chloride of lime was recommended as a disinfectant.

A bed was brought in from the porch so that Mary might sleep alone until she recovered. Mrs. Amos called her family doctor so that Mary was brought under good medical care during her illness and convalescence.

The public health nurse continued to visit this family frequently in order to follow Mary's progress and help to prevent a relapse as well as to teach the mother how to protect other members of the family and to recognize early signs of this illness. Mary recovered in four weeks and was allowed to return to school. Her appetite returned as the jaundice cleared and she began to put on some of the weight she had lost. Her mother watched closely for signs of relapse, such as anorexia, listlessness, and loss of weight. Mary's teacher was interested in taking part in control measures; she was well informed about symptoms and arranged Mary's activities so that she would not become over-tired.

Mary's sister, Jane, developed symptoms of lassitude and anorexia three weeks after the onset of Mary's symptoms. Her parents had learned to be very much aware of these early

signs and called the family doctor as soon as they appeared. Jane was put to bed immediately and her diet was carefully planned. Jaundice developed a few days later. She recovered in three weeks.

Thirteen known cases of infectious hepatitis developed in the community in a period of three months but the source of infection was never found. Seven of these cases occurred within a week. Ten of the cases were children and three were adults. Two of the adult cases occurred in men, who suffered mild and transient illness which caused only a few days' absence from work.

Since Mary's illness was not diagnosed until well after the onset of the disease, no measures of control were in force. Due to the long period of incubation, we were unable to trace the source of infection. Infectious hepatitis is a new problem to cope with in rural public health practice. All studies done to date seem to have been carried on where large groups of people are congregated.

Studies show relapse frequently occurs over a long period of time so that it becomes advisable to be alert to symptoms which suggest infectious hepatitis in a community where cases have been found.

Program and Control

In the event of an epidemic of infectious hepatitis in the community a program for the control of the disease would have to be instituted and the present public health program adapted to take care of these special needs in such a way that regular services would not suffer.

One of the methods of control would be to inform and invite the cooperation of local doctors, as well as staffs of hospitals and schools. Staffs of hospitals might wish to review symptoms, mode of transmission, and treatment. Teachers with an understanding of symptoms, mode of transmission, and effective measures of control could take part in the program by being alert to early signs of illness and by emphasizing the importance of hand-washing to the students. Janitors would be required to participate in carrying out necessary measures of sanitary control if a case occurred in the school.

Because of the possible danger of transmitting serum hepatitis through inoculation, it might become necessary to take special precautions in immunization programs. It has been suggested that anyone who has had the disease should not give a blood transfusion for at least a year.

Public health nurses would have to be alert to subclinical symptoms described by the patient or family during home visits and other interviews.

Early reporting of diagnosed or suspected cases would help to reduce the severity of symptoms and length of illness and would also be valuable in compiling statistics for further study.

The cooperation of doctors, hospital staffs, schools, and health departments will help to protect the families of the community against the spread of infectious hepatitis.

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Nursing Sisters' Association

The *Saint John Unit*, at a recent meeting held at Lancaster Hospital, made plans for a luncheon to be held on Remembrance Day as well as a visit to the Cenotaph.

A Civil Defence Course for High School Students

KATHLEEN DEMARSH

Average reading time — 4 min. 24 sec.

BY INTRODUCING a uniform Civil Defence course into its high school curriculum, Saskatchewan's officials hope to prepare a group of young men and women, not only to be of some immediate assistance in case of disaster but to take an active interest in civil defence activities on a local and a provincial level, as free citizens in a free country.

The course in its present form has been granted one-half credit and makes provision for Grade XI and Grade XII students to gain information regarding the principles of Atomic, Biological and Chemical Warfare and to secure practical experience in first aid. It includes, also, a special section in home nursing for the girls and a special section in fire-fighting and rescue work for the boys.

In order that high school teachers might be prepared to administer this course more effectively a special Civil Defence school for teachers was held at Valley Centre, Fort Qu'Appelle in June, 1951. The school lasted six days, commencing June 22 and finishing on June 29, which allowed teachers, who would normally have been supervising examinations, to be in attendance.

KATHLEEN DEMARSH

Representatives from 18 collegiates and four-roomed high schools throughout Saskatchewan, from North Battleford to Swift Current on the east and from Sturgis to Indian Head on the west, gathered together to learn not only the aims and purposes of the high school course but to become themselves equipped to take an active part in the civil defence activities of their respective communities.

The school was operated in two sections. While a more general course in civil defence was being conducted in one room for the men, the women were busy in the next room trying to absorb in one short week the total content of a more specialized course in home nursing.

The operation of the two schools concurrently enabled the women to sit in on the lectures on the Medical Aspects of A.B.C. Warfare and to join with the men again for the very informative demonstrations and practical experience given in fire-fighting. It also enabled the men, if not to acquire any particular skill in home nursing, to at least gain an appreciation of the type of training that is available across Canada to women who are interested in that phase of civil defence work.

Red Cross *Home Nursing*, which is the approved text for the home nursing section of the Civil Defence course for high school students, provided the basis for the special course for high school teachers. Provision was made during the course for each

Miss DeMarsh is director of Outpost Hospitals with the Saskatchewan Division of the Canadian Red Cross Society. Currently she is enrolled for study at the University of Toronto.

teacher to practise at least once, under supervision, each of the selected procedures (there were 26) after these had been demonstrated.

There were 11 women teachers and two nurse instructors which made possible the supervised practice which otherwise could not have been arranged effectively in so concentrated a course.

Special reading assignments were given so that the actual teaching could be limited to highlighting the important aspects of patient care with emphasis on:

1. *Principles* of care rather than detail of procedure.
2. *Attitudes:* (a) toward the total problem; (b) toward the patient.
3. *Responsibilities* regarding patient records, reporting of unusual situations; need to work under the supervision of more highly trained personnel.
4. *Probable adjustments* in routine of patient care during disaster period.

On completion of the course the group was divided into two sections—firstly, to evaluate the six-day course and, secondly, to study the whole problem of effectively handling an introductory course in home nursing in the school set-up.

One of the interesting features of the course was that it served to create a bond, momentarily at least, between the nursing and the teaching professions. The teachers themselves, far from feeling competent to step out and teach home nursing on the completion of their course, expressed a desire to get further practical experience in hospitals and a hope that, whenever possible, and particularly in connection with the home nursing course for high school girls, the two professions would work together at the local level for the common good of the people they serve.

What happens to the home nursing section of the Saskatchewan Civil Defence course is, then, as much the responsibility of local registered nurses as it is of the teachers charged with the administration of the course—and we are confident that our registered nurses will rise to the occasion.

Saving Sight of Desert People

LEONARD RULE

Men who spend their lives looking over vast distances in clear air and good light would be expected to have better eyesight than office workers or watch-makers. In fact they have not. Vision is largely a muscular effort, like lifting a load. Exercise of the proper muscles makes it easier to lift the load. Exercise of the eye muscles helps people to see better. Practice at reading enables everyone to read more easily; practice at looking over the deserts of Saudi Arabia helps the Bedouin to pick out his sheep more readily. The sailor accustomed to the dancing light on the sea will spot a small boat long before the landsman who is dazzled by the glints of the sun.

Changing his job, the countryman may find that his eyes are not good for the new work. That is probably because there was a defect before about which he knew nothing. Changing habits among the desert peoples are making them realize that, while their eyes were quite satisfactory for herding sheep, they are not nearly so good for reading books or for finding out what is wrong with a car motor.

So it comes about that the people in Saudi Arabia are gradually growing accustomed to the wearing of spectacles. Even more important, they are beginning to take more care of their eyes. The traditional remedies for eye diseases are being abandoned in favor of the new, more effective treatment now available.

New in the history of Saudi Arabia is the appointment of a Minister of Health. This year one of the Royal Princes will assume this office. His task will be to expand and improve the health services of the country. Already Saudi Arabia is able to boast that its medical services are as freely available to the poorest Bedouin as to the richest prince.

Owing much to British-Arab cooperation is the Jedda Ophthalmic Hospital which was

(*Turn to page 896*)

Nursing Profiles

Mildred F. Weir has assumed her duties as the first registrar with the Registered Nurses' Association of Ontario. The legislation passed earlier this year by the Ontario government, which placed the responsibility for the annual registration of all graduate nurses in the province under the R.N.A.O., necessitated the enlargement of the provincial office staff. Miss Weir was a happy choice to fill this important position.

During the first two years following her graduation from Toronto Western Hospital, Miss Weir engaged in private and general staff nursing. The Dr. H. A. Beatty Scholarship had been awarded to her for post-graduate study and she had secured her certificate in teaching in schools of nursing from the McGill School for Graduate Nurses. From 1935 until war in the far east drove her out, she was on the staff of the Canadian Presbyterian Mission Hospital in Taihoku, Formosa. Returned to Canada in 1941, she became administrator of the Hugh Waddell Memorial Hospital in Canora, Sask. In 1944, she became assistant superintendent of the Sarnia (Ont.) General Hospital. She returned to McGill two years ago and received her Bachelor of Nursing degree this year, majoring in administration in schools of nursing.

Lyonde, Toronto

MILDRED F. WEIR

Lois W. Lethbridge is the assistant executive secretary of the Manitoba Association of Registered Nurses. Born and educated in Winnipeg, Miss Lethbridge graduated from the General Hospital there. After a brief period on the staff she joined the Henry Street Visiting Nurse Service in New York where she was employed for seven years. Returning to Canada, she became the matron of the hospital in Arcola, Sask. Until her new appointment this year, Miss Lethbridge had served faithfully as superintendent of the Portage la Prairie General Hospital, Man.

Before beginning her training, Miss Lethbridge secured her certificate in home economics from Macdonald College, Que. It was natural, therefore, that she should serve for many years on the Examining Committee of the M.A.R.N., responsible for the papers in Nutrition and Diet Therapy. She was a member of the Board of the nurses' provincial association for four years, was a director of the Hospital Association of Manitoba for twelve years. Currently, she is chairman of the Curriculum Committee of the Practical Nurses' Advisory Council. Time and weather permitting, after all the other jobs are done, Miss Lethbridge turns to gardening for relaxation.

Winonah Lindsay is the new assistant secretary-registrar of the Association of Nurses of the Province of Quebec. A graduate from the Phillips School of Nursing, Homoeopathic Hospital, Montreal, holding her B.N. degree from McGill University, Miss Lindsay has had a rich and varied experience. General

Van Dyck, Montreal

WINONAH LINDSAY

staff work in communicable diseases at the Alexandra Hospital, Montreal; student supervisor at Homoeopathic; insulin therapy nurse and later assistant supervisor at the Verdun Protestant Hospital; a stint in the R.C.A.M.C. that took her to the British Isles and Northwest Europe; and, until recently, educational assistant at Lancaster (D.V.A.) Hospital, Saint John, N.B.— all of this experience has produced a well-rounded personality who will fit well into the busy rounds of provincial office life. Miss Lindsay relaxes with an artist's paint brush in her hand.

On either side of our vast country, nurses are attached to the staffs of the provincial departments of health to give guidance to the staff nurses in developing their mental hygiene programs.

LUCILLE GIOVANDO

Lucille Giovando, in British Columbia, is a graduate of Vancouver General Hospital. She holds her B.A. and B.A.Sc. degrees from the University of B.C. Last year she received her Master of Public Health degree from the University of Minnesota, specializing in mental hygiene. Miss Giovando's background of experience includes five years as staff nurse in Kelowna, Cumberland and Powell River, B.C., before becoming a health unit supervisor. Since 1949 she has been on the staff of the Health Branch of the Department of Health and Welfare of British Columbia as a consultant in public health nursing.

Lois O. Smith in New Brunswick holds the position of supervisor, mental health nursing, with the provincial public health nursing service. Miss Smith, who was born in Marysville, N.B., graduated from the McLean Hospital in Waverley, Mass. For a few years she occupied staff positions in psychiatric hospitals before becoming superintendent of nurses at the Provincial Hospital in Saint John. Interest in public health nursing led her to obtain her certificate in this field in 1944 from the University of Toronto. Miss Smith engaged in rural public health nursing service in N.B., later going to Sault Ste. Marie as school nurse. Last year she returned to the University of Toronto for advanced study in administration and supervision in public health nursing, and mental health, thus rounding out her preparation for the new field of activity she is now developing.

Two new university appointments of interest have been made this autumn. **Edith J. Green** has joined the faculty of the McGill School for Graduate Nurses as lecturer in teaching in schools of nursing. **Frances Margaret Riddell** is an instructor in the Department of Nursing Education, McMaster University, Hamilton, Ont.

Jacoby, Montreal

EDITH J. GREEN

Miss Green, who is a graduate of the Royal Victoria Hospital, Montreal, had already earned her B.A. (University of B.C.), her B.S. in library science (U. of Washington) and had been active for several years as a librarian before entering nursing. She added to her qualifications by securing her certificate in teaching and supervision in schools of nursing from the McGill School. Staff work at the Montreal Neurological Institute and the Vancouver General Hospital preceded her appointment to the teaching department at the Royal Jubilee Hospital, Victoria, where

she has been educational director for the past four years.

Harold G. Rose

FRANCES RIDDELL

Miss Riddell secured her B.A. from McMaster University and graduated from the Hamilton General Hospital in 1948. Last summer she completed the work for her Master of Science degree from Boston University, holding a Kellogg Fellowship for the latter study. She served, in the interim, as staff nurse at the St. Catharines General Hospital and with the Hamilton Branch of the Victorian Order of Nurses.

VERA B. EIDT

Vera Beatrice Eidt, superintendent of Trail-Tadanac Hospital in Trail, B.C., was honored with a nomineeship at the convocation exercises of the American College of Hospital Administrators held in St. Louis recently. A graduate of the Guelph General Hospital, Ont., Miss Eidt was a ward supervisor at the Royal Inland Hospital, Kamloops, B.C., for a number of years before enrolling for the course in hospital administration at the University of Toronto. During World War II Miss Eidt saw service with the R.C.A.M.C., making several trips on the hospital ship *Letitia*.

Rice, Montreal

ELSBETH GEIGER

Elsbeth Geiger is the new director of nursing at the Queen Elizabeth Hospital in Montreal. After graduating from the Royal Victoria Hospital, Montreal, in 1942, Miss Geiger engaged in operating room work until she joined the United States Public Health Service in 1944 for a two-year tour of duty with UNRRA, followed by a like period at the United States Marine Hospital, Staten Island, N.Y. She holds her B.N. degree from McGill University and her M.A. from Teachers College, Columbia University.

Edith Marion Pullan is director of nursing at the Provincial Mental Hospital, Essondale, B.C. Born and educated in Vancouver, Miss Pullan graduated from the General Hospital there in 1940. She became interested in psychiatric nursing through a post-graduate course at Essondale the following year. After serving as a head nurse there for two years, she enrolled at the University of British

Columbia and secured her certificate in teaching and supervision, later completing the requirements for her B.A.Sc. degree. She returned to Essondale as instructor. For the past three years she has been head instructor in charge of the total training program for both men and women psychiatric nurses. She has taken an active part in various committees of the R.N.A.B.C., is an enthusiast about hobbies — leather work, metal work, oil painting, gardening — and is happiest when time permits her to indulge in her favorite pastime of horseback riding.

EDITH M. PULLAN

Ruth A. Bourne, a graduate of the Toronto General Hospital, has been working as medical social worker with the Ontario Division of the Canadian Arthritis and Rheumatism Society since midsummer. Miss Bourne received her training in public health nursing from the University of Toronto and worked for four years as a public health nurse with the Ontario Division of the Canadian Red Cross Society. She joined the R.C.A.M.C. in 1942 and saw service in Europe. At the close of the war she turned to social service, receiving her diploma from the University of Toronto. She was employed, first, by the Children's Aid Society, Hamilton, and later as a medical social worker at Sunnybrook Hospital, Toronto.

Pearl McIver, chief of the Division of Public Health Nursing with the U.S. Public Health Service, and **Alma C. Haupt,** director of the Nursing Division, Metropolitan Life Insurance Company, New York, were the recipients of Outstanding Achievement Awards presented by the University of Minnesota in Minneapolis on October 8. Miss McIver's citation described her as "celebrated nurse and pioneer in the federal health services." Internationally known for her leadership in both nursing and public health fields, Miss McIver was the first public health nurse to be elected president of the American Nurses' Association.

Miss Haupt is well known to Canadian nurses through the close personal contact she has had with many of them through the years. Miss Haupt's citation read: "Eminent contribution to the health of a nation at war and at work."

In Memoriam

Ina (Gillan) Beer died in Charlottetown, P.E.I., on September 11, 1951, after an illness lasting several months. A graduate of New York Post Graduate Hospital, Mrs. Beer enlisted in the C.A.M.C. early in World War I, serving in base hospitals in France and England and after the war at Rena McLean Memorial Hospital, Charlottetown, and at Ste. Anne de Bellevue, Que.

Mrs. Beer served with distinction for 24 years in public health nursing in Prince Edward Island, with the Red Cross and the Department of Health and Welfare. She was a past president of the P.E.I. Registered Nurses, Association and of the Nursing Sisters' Association.

* * *

Frances (Belwa) Bull, who graduated from the Royal Victoria Hospital, Montreal, in 1923, died there on September 22, 1951, following a lengthy illness.

* * *

Margaret (Keefer) Cadenhead, who graduated from Presbyterian Hospital, New York, and who served in the obstetrics department of the Toronto General Hospital for

several years, died in Ottawa on July 26, 1951.

* * *

Gertrude (Simpson) Connell, who was on the staff of the Red Cross Hospital at Thessalon, Ont., for the past three years, died of a sudden heart attack on September 27, 1951.

* * *

Beatrice Anna (Kilborn) Cowell, who graduated from the Owen Sound General and Marine Hospital, Ont., in 1911, died in Toronto, on August 23, 1951, in her 61st year. During World War I Mrs. Cowell served overseas with the C.A.M.C. She was the first public school nurse in Lincoln County in Ontario.

* * *

Cora (Peck) Dempsey, who graduated from the Belleville General Hospital, Ont., in 1902, died there in May, 1951, following a lengthy illness.

* * *

Margaret J. Dow, who had engaged in hospital and private nursing in Halifax for the past 20 years, died at Fair Vale, N.B., on August 17, 1951, following a brief illness.

* * *

Isabel Gibson, who graduated from the Calgary General Hospital in 1919, died in Lethbridge, Alta., on September 26, 1951, at the age of 54. For many years Mrs. Gibson had worked devotedly with the Lethbridge branch of the Canadian Cancer Society. For the past two years she had operated a cancer information centre and dressing station in that city.

* * *

Margaret (Lauder) Lewis, who graduated from the Toronto General Hospital in 1916, died on July 23, 1951.

* * *

Olive F. Lewis, of Edmonton, met with a fatal accident on November 26, 1950.

* * *

Marion C. Maxwell, a native of Saint John, N.B., who received her professional training in New York, died on September 5, 1951, in Saint John. Miss Maxwell served overseas during World War I and continued her nursing service at Lancaster Hospital, Saint John, and also at Ste. Anne de Bellevue Hospital, Que.

* * *

Kathleen Moran, aged 24, who graduated from St. Paul's Hospital, Vancouver, in 1949, was reported missing following the disappearance of an aircraft on which she was stewardess in July, 1951.

Annie Reid, who graduated from the Montreal General Hospital in 1918, died in Los Angeles on August 17, 1950. In tribute to her outstanding work in the Hospital of the Good Samaritan over a period of many years, the Annie Reid Memorial Fund was set up this year by the board of directors of that hospital. Miss Reid served for three years in veterans' hospitals following World War I. She was superintendent of nurses at the Sherbrooke Hospital for a time before going to the United States.

* * *

Alice S. Stark, who was one of the early school nurses in New Westminster, B.C., serving there for 25 years, died on September 19, 1951, at the age of 77. Miss Stark had retired about 10 years ago.

* * *

Ellen Webster, who was matron many years ago of the old Nicholls Hospital in Peterborough, Ont., died there on September 23, 1951, after a long illness. She was 79 years of age and had been retired for many years.

* * *

Charlotte Letitia Wood, who graduated from the Toronto General Hospital in 1924, died suddenly on July 29, 1951.

If a toddler is not eating well it is, as a rule, not because of a direct dietary problem and giving the mother a feeding schedule is not the solution. There are other reasons, usually of a psychological nature, which must be taken into account. Over-anxiety of the parents, and particularly the parents of a first child, is one of the commonest causes of feeding problems in this age group. Unsatisfactory mother-child relationships during the first year can also lead to the development of behavior problems of which refusal of food is a common expression.

—*Working Conference for Public Health Nurses*

The sensation of thirst in healthy individuals is sufficiently strong to ensure a sufficient intake of fluid. The desire for fluids in sick or injured individuals, however, may be depressed or weakened to such an extent that the fluid intake becomes inadequate. A normal adult, at rest and not sweating, requires 1,800-2,500 cc. of water every day. The amount of fluid lost by abnormal means must be added to this.

— THERAPEUTIC NUTRITION

Public Health Nursing

Medical Care Programs and Public Health Nursing Practice

STANLEY RANDS, M.A.

Average reading time — 20 min. 24 sec.

NEW DEVELOPMENTS in the general field of public health naturally bring changes in public health nursing practice. The "Report of the Study Committee on Public Health Practice in Canada" emphasizes the close relationship between public health nursing and other aspects of public health programs. It calls attention to many of the current trends and future prospects in public health policy and practice and raises questions as to the effect of these changes on public health nursing practice. Since one of the major trends in public health is the increased provision of medical and hospital care by taxation, one of the important questions for the future is: "What is the relationship between the provision of medical care and the development of public health nursing service?"

Saskatchewan has several forms of health insurance programs financed by taxation. These include the municipal doctor system, the Swift Current regional medical care program, public medical care for old age pensioners, blind pensioners, and those in receipt of Mothers' Allowances, and the Saskatchewan Hospital Services Plan. This article will outline briefly these several programs, as a background to a consideration of the relationship between medical care and public health nursing.

THE MUNICIPAL DOCTOR SYSTEM: The municipal doctor system in Saskatchewan originated in 1914 and was embodied in legislation in 1919. The basis of the system is the engaging of a physician or physicians by one or more municipalities on a contract basis. Over the years the system has been modified, extended, and improved until now about 200,000 people — almost one-fourth of the population of the province — is included. In 1950, municipal doctor contracts were in effect in 107 rural municipalities, 50 villages, and 16 towns. Most of the contracts provide service to all residents except those covered by a provincial or federal program. Most of the plans are financed by a property tax alone but provincial legislation, passed in 1939, permits a personal tax for the purpose and some municipalities now use a combination of personal and property tax. Provincial legislation limits the personal tax that may be levied to $40 per family annually.

The basic service provided under the Plan is that of the general practitioner. More than half of the contracts limit the benefits to general medical services, including minor surgery, maternity care, and such public health work as examination and immunization of school and preschool children. In almost one-half of the municipal doctor plans, the municipalities have entered into additional contracts with doctors to provide surgical benefits. In some cases payment is made for referrals to doctors outside the municipalities. In these cases, and also in a few cases where the municipality has contracts with more than one physician, the patient is not lim-

Mr. Rands is assistant director, Division of Health Education, Department of Public Health, Saskatchewan.

ited to one doctor. In some plans the patient has free choice of specialist while in others a municipality only covers payment when the referral has been made by the municipal doctor.

Provincial grants in aid of approved municipal doctor plans were initiated by the Health Services Planning Commission in 1945. These grants are an aid to municipalities in retaining the services of a physician and an encouragement to raise local standards of service.

The Swift Current Medical Care Program

The best known of the Saskatchewan experiments in health services is probably the Swift Current prepaid medical care program. This project was launched in July, 1946, as the first prepaid health insurance program in Canada to cover all the residents of a given area. It has aroused wide interest as an experiment in prepaid health services and after almost five years of experience has become recognized as a successful pilot project.

The program was launched by the regional board of the Swift Current health region and the participants are all residents of that region — about 50,000 people. At the beginning, provision was made for both medical care and hospital benefits. The hospital benefits were included only for six months since the province-wide Saskatchewan Hospital Services Plan came into effect on January 1, 1947. The benefits of the Swift Current plan include full medical, surgical, and obstetrical care rendered by general practitioners within the region and a specialist in radiology; referral of certain kinds of cases to specialists outside the region; hospital out-patient services; and dental service for children under 16 years of age.

The cost of services within the region is covered in full by the plan but the patient pays one-half the fee of specialists outside the region to whom he has been referred. These services in the region may be obtained in the physician's office, in the hospital, or in the home. The patient has free choice of physician and may change doctors whenever he so desires.

Payment of physicians' accounts is from a pooled fund and on a fee-for-service basis. The accounts are paid *pro rata* in the proportion which the total fund bears to the total of accounts submitted. In 1950 the funds for payment of medical services totalled $445,000. When the program was first organized there were 19 physicians serving the region; by the end of 1950 there were 35 physicians in addition to a full-time specialist in radiology. The medical care program is financed through a combination of a personal tax, a land tax, and provincial grants. The region contributes about 90 per cent of the cost through the personal and land tax. The remaining 10 per cent is supplied by the provincial grants. These grants are apart from the cost of the public health program of the region, of which the provincial government pays two-thirds and the region one-third. Collection of the personal and land tax is the responsibility of each urban and rural municipality. Payment of the medical care tax on behalf of indigents is made by the responsible municipality and no distinction in eligibility for service is made on this account.

The administration of the medical care program is in the hands of the regional health board. The board is made up of 12 representatives from four district health councils and the city of Swift Current. Each district health council consists of one representative from each rural or urban municipality in the zone.

In the administration of the medical care program, the regional board has the assistance of a medical advisory board elected by the district medical society. The regional medical health officer attends all meetings of the regional board in an advisory capacity. The secretary-treasurer of the regional board acts as a full-time executive officer, directing the staff from day to day in administrative activity.

Recipients of Public Assistance

Saskatchewan has two types of medical care programs for recipients of public assistance: (a) for those re-

ceiving continuing assistance such as old age and blind pensions and Mothers' Allowances; and (b) those receiving social aid on a short-term basis. The provincial program to provide health services for these groups began in 1945.

Beneficiaries of this program are generally persons in low income groups who require, in general, more medical care than persons in higher income brackets. They are also predominantly older persons who require more medical care than other age groups in the population. Beneficiaries receive, without charge, physicians' services in the home, office or hospital, including major surgery; hospital services, including in- and out-patient care; special nurses when required; most dental services; optical services; physiotherapy; chiropody; most drugs and appliances, excluding patent medicines. In the first three years of the program drugs were provided free of charge but since that time, as a result of rapid increases in the consumption of drugs, it became necessary to require the patient to pay 20 per cent of the cost of most drugs.

These health services for public assistance cases are paid for from the general funds of the province. All accounts are paid according to detailed fee schedules agreed upon with representatives of the various professions and associations involved. In the year 1949-50 virtually all practising physicians in the province rendered services under the program.

Two out of every three beneficiaries of this plan receive some type of health service during each year. Physicians' services are the most frequently used, being obtained by 56 per cent of all beneficiaries during 1948-49. There is a high rate of physicians' calls, especially hospital calls, under this program. This rate is higher than in the Swift Current scheme, probably largely because of the older age group covered by this program and the low income status of the beneficiaries. The high rate of hospital calls is due partly to the fact that many rural hospital patients are treated in hospitals rather than at home. It is also due in part to the lack of an adequate number of alternative facilities for many custodial-type cases, which are presently hospitalized in general hospitals under the continuing care of a physician.

The second program of medical care for recipients of public assistance is that which provides health services for social aid cases. These are short-term social aid cases and, in order to qualify, persons must be certified by the Department of Social Welfare or by the Local Improvement District Branch of the Department of Municipal Affairs, as being in need of health services. Recipients include transients, Métis, civilian rehabilitation cases, government wards, and medical indigents in northern areas. These beneficiaries are entitled to receive services similar to those provided under the program outlined above.

The Saskatchewan Hospital Services Plan

The principle of prepaid hospital care insurance, established on a province-wide basis in 1947, had been applied in various forms for more than 30 years. The earliest plans were introduced by municipalities and union hospital districts. In 1946, programs covering all residents of two of the organized health regions were adopted. The purpose of hospital care insurance plans is twofold: to make hospital services available to all without regard to the patient's ability to pay, and to assure hospitals of regular payment and adequate revenue in order that they may provide essential services of high quality.

The Saskatchewan Hospital Services Plan did more than extend to a province-wide basis the principle of prepaid hospital care pioneered by the earlier efforts. It added to the principle of prepayment the additional advantage of a broader and more stable tax base and the principle of universal coverage. The Plan thus aimed to remove the economic barrier to necessary hospital care for all Saskatchewan residents and to stabilize the financial operation of hospitals throughout the province.

Coverage is provided to all persons

who have resided in Saskatchewan for six months who are not already provided with hospital care under special provincial or federal programs. Participation is compulsory except for residents of the Northern Administrative District who may join voluntarily. Recipients of social assistance are covered by the Plan through payment of the hospitalization tax by the provincial or municipal government agency responsible for their hospital care. The program makes hospital care insurance available to all, including persons who may be most in need of insurance and who would not likely be eligible for insurance protection under any other system.

Beneficiaries receive most of the services which are normally provided by the hospital concerned when they are admitted as in-patients, provided that there is medical necessity for in-patient care. These benefits include public ward or minimal accommodation, including meals, special diets, and general nursing care; use of operating and case rooms; surgical dressings and casts as well as other surgical materials and use of equipment required; x-ray and other diagnostic procedures, including laboratory procedures; x-ray and radium treatments; anesthetic agents and equipment; physiotherapy and most drugs in general use. All Saskatchewan beneficiaries are covered for a period of 60 days' hospitalization in any one year, in approved hospitals anywhere in the world. Out-of-province payments are limited to $5.00 per day for beneficiaries and $1.00 per day for newborns.

The Hospital Plan is financed partly from the proceeds of a personal hospitalization tax and partly from other funds of the province. Since April 1, 1950, a one-third share of the revenue from a sales tax levied under the provisions of The Education and Hospitalization Tax Act, 1950, has been included in such other funds allocated to the Plan.

Under the Hospital Plan a very large volume of hospital care is being received by Saskatchewan residents. In 1950, hospital bills were paid by the Plan in respect of 155,951 cases of adults and children and 19,201 newborns. A total of 1,883,614 days of care were provided. The average length of stay for adults and children was 10.8 days.

Relationship of Prepaid Medical Care and Public Health Nursing

The relationship of prepaid medical care and public health nursing practice will, undoubtedly, be of great importance in the long-term development. On the one hand, medical care programs may be expected to have a direct effect on the functions of the public health nurse. It may be assumed, for example, that prepaid medical care makes it easier for the nurse to obtain necessary medical follow-up when it is recommended. This, in turn, should enable the nurse to save time on repeat visits and to use that time for other preventive health work.

At the same time, medical care programs may be expected to make possible a more effective total health program and one in which the functions of the nurse will have a somewhat different emphasis than they have at the present time. The Baillie-Creelman survey reveals that public health agencies are not using the time of nurses fully in those tasks for which the nurses are especially qualified. The report recommends that each public health agency evaluate the work being done by its public health nurses in order to relieve them of tasks which could be done by other personnel and to use their time more fully in those functions which are distinctively those of a public health nurse. Such a re-assessment of the functions of the public health nurse should be carried out in relation to a similar re-assessment of the functions of other health personnel and should lead to a gradual re-adjustment of the functions of all personnel in public health. It is likely that the full benefits of medical care programs will only be realized if such a readjustment of functions is gradually brought about.

Where medical care programs have been in operation, problems have arisen which must be solved if the full benefits of these programs are to be

derived. It seems likely that the public health nurse can make an important contribution toward solving these problems. This can only be expected, however, if means can be found to achieve an optimum use of the public health nurse's time. Certain changes are now taking place which may be expected to release some of the nurse's time for her more essential functions.

The Baillie-Creelman survey found that, in all but one of the areas studied, the single service receiving the most public health nursing time is the school health service and that everywhere a high proportion of the total home visits made by public health nurses is for the school service. In many areas it was found also that the nurses felt there was an excessive amount of clerical work in relation to school health services. This problem of the disproportionate use of the public health nurse's time in school health services will be largely solved through a change of emphasis now generally agreed as desirable in the school health program. This change involves the teaching staff undertaking a larger share of responsibility for school health services and, in particular, carrying out the basic health screening of the pupils, referring necessary cases to nurses and doctors. This new emphasis, which has already been approved in principle by the Saskatchewan Department of Education, will relieve the nurse of the burden of a regular examination of every child and will make more of her time available for those services for which she is especially trained. The Baillie-Creelman report concludes that:

> Until such time as the teaching of health and part of the supervision of health of the pupil is generally accepted as a responsibility by the teaching profession, public health will not succeed in establising either an adequate referral system in schools or a basic knowledge of health in the minds of the pupils.

The Baillie-Creelman report also suggests that in the public health agencies generally, changes should be made to relieve the nurse of clerical and other duties which can be satisfactorily performed by others. It may then be concluded that changes, now under way and generally recommended, will bring about a re-allocation of the nurse's time so that she will have more time available for tasks which she is not now able to perform.

One of the possible consequences of such changes would be that the public health nurse would be in a position to help solve some of the problems associated with the provision of medical care — again with the objective of increasing the total services actually provided by existing health resources. An example might be the problem of unnecessary use of hospitals which tends to accompany prepaid hospital care. Could public health nurses help to relieve the pressure on hospitals if a closer relationship were developed between them and the hospitals and doctors? Could the doctor not release some patients from hospital days or even weeks earlier if he knew that a public health nurse could make regular visits? Could not some long-stay hospital cases be adequately cared for at home if a nurse were available, under a doctor's direction, for such services as giving injections?

It is quite true that with the present shortage of public health nursing personnel, no extensive amount of home nursing could be undertaken but, with the nurse relieved of certain other duties as suggested above, it is quite possible that she could increase the number of volunteer workers by classes in home nursing.

The Baillie-Creelman report makes a further suggestion that implies a redistribution of functions in the interest of a more efficient total health service. It suggests that school health services should be based on information supplied by the family physician with regard to the health of children under his care. The idea is advanced that in this way more adequate information would be available to the teacher. Thus, the health teaching program, as well as the teacher's observation of the pupil's health, would be more soundly based. The report asks whether this practice would not at the same

time enlist a more active interest in preventive medicine on the part of the private practitioner. The suggestion implies the development of a closer relationship between the school, the public health nurse, and the private physician. As suggested in the Baillie-Creelman report, such a development would be an important step in a redistribution of responsibilities among health personnel in order to obtain fuller value from the contribution of each. Such a change appears more likely to come about where a medical care program removes the economic obstacle to referral of children to a doctor whenever necessary. A further increase in the effectiveness of school health programs can be expected under prepaid medical care since it is obviously much easier for nurses to induce parents to initiate medical corrections when no immediate financial outlay is involved.

In the Good Old Days

(*The Canadian Nurse*, DECEMBER 1911)

"The selection of the school wherein the would-be nurse is to receive her training is one of the important preliminaries, as much depends upon the selection; then follows the formal application and appointment. During her first two or three months as probationer, she has many disconsolate moments but consoles herself with the prospect of the approaching day when she will don the coveted uniform. Innocently she believes that thereafter her horizon will reflect nothing but sunshine. Alas, the road is long and its perspective deceiving."

* * *

"A very simple and easy method of removing plaster bandages requires only a little vinegar and a simple knife — even a pocket-knife will do. The future line of section of the plaster should be wetted with a sponge soaked in vinegar. After a minute the softened dressing may be cut at this place without the least difficulty or any discomfort to the patient. This makes it possible to remove in one minute a plaster dressing composed of 80 turns of the bandage and sufficient to hold a fracture of the thigh."

* * *

"Gasoline is the best solvent for the face of adhesive plaster. The liquid should be freely applied with a wad of cotton. The plaster may then be removed without violence or depilation. So effectual is the solvent that the surgeon will not care whether the cementing material does or does not come away with the cloth."

* * *

"The care of the patient is not the problem that confronts the well prepared nurse in private practice. What puzzles and sometimes confounds her is the attending circumstances with which she must cope and these are of such diversity that the ordinary hospital instruction is quite an inadequate preparation. Indeed, one actually hesitates to tell the innocent pupil nurse the problems that may confront her and thus possibly frighten her or make too conspicuous certain phases of nursing life."

* * *

"A series of experiments have been made for the purpose of determining the manner of the spread of infantile paralysis. Dr. Neusteadter took collections of dust from the walls, floors, and wooden trimmings of different rooms in which there were 19 cases of infantile paralysis. The dust was dried, sifted, macerated, and dissolved in normal saline which was injected into the brains of six monkeys. Five showed prominent symptoms of paresis, in some cases paralysis being complete. Thus an important chapter has been added to medical knowledge."

Young children between the ages of three and six do not understand the meaning of war. Certainly the child will be interested in what he sees and hears but will be concerned only if war intrudes into his family life. There is anxiety if he is separated from his mother, for he fears she will not come back. Separation from the father is less disturbing unless the mother transmits her own anxiety to the child. — *Public Health Nursing*

Institutional Nursing

The Procedure Committee Revises Some of the Patient's Records

MARGARET ALLEMANG

Average reading time — 6 min. 24 sec.

WHY CHANGE?

FOR A LONG TIME the doctors in our hospital had been saying that our nurses' records were of little value. Information they desired was not recorded whereas many irrelevant facts, of no concern in the course of diagnosis, treatment, and care of the patient, were continually being noted. The nurses, likewise, were discontented for they were spending much valuable time recording this so-called irrelevant material. No active measures were taken to remove the cause of the general dissatisfaction, however, until the Procedure Committee decided that to evaluate and to revise those patients' records, which were the special responsibility of the nurse, would be an interesting and worthwhile project.

OBJECTIVES OF PROCEDURE COMMITTEE

In our hospital the Procedure Committee — whose membership included two head nurses, three clinical instructors, the nursing arts instructor, and the educational director — functions for the express purpose of evaluating nursing practices and procedures and for making revisions as necessitated by changing conditions within the hospital and by advancing medical thought. When revisions are made the committee aims always to protect the safety and rights of the patient and to use to best advantage the limited time at the nurse's disposal. By streamlining all procedures it tries to prevent the loss of nursing hours in time-consuming practices from which no one benefits.

At the time this paper was written Miss Allemang was educational director at the Belleville General Hospital, Ont. She is now on the faculty of the School of Nursing, University of Toronto.

INFORMATION DESIRED ON THE PATIENT'S RECORD

1. *The Graphic Clinical Record:* With these objectives in mind, the committee started to investigate two forms — the temperature graphic sheet and the nurse's record. It was decided that these forms should be simple, easy to use and, if possible, self-explanatory; that duplication of material should be reduced to a minimum, and the material recorded should be relevant, concise, and complete. As the first page of the patient's record is probably the one most used by the busy doctor when he wishes to note the changes that have occurred in his patient during his absence, the committee thought that as much significant data as possible should be recorded on this sheet. Space should be allowed, it was agreed, not only for temperature and pulse graphs but also for such significant information as diagnostic tests, medications and treatments given, intake and output summaries, blood pressure readings, height, weight, diet, and the defecation record. It was also thought that the nurse responsible for the care of the patient should be responsible for the recording of this information and that she should sign this sheet with her full name at the completion of her period of duty.

2. *The Nurse's Observation Record:* Although the graphic clinical record would give a fairly complete picture

CLINICAL SHEET—BELLEVILLE GENERAL HOSPITAL

Name Age Ward No.

Date

Days After Admission

Days After Operation

Pulse	Temp. F	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12
150	106																								
140	105																								
130	104																								
120	103																								
110	102																								
100	101																								
90	100																								
80	99																								
70	98																								
60	97																								
50	96																								

Admission, Discharge, Operation, Removal of Sutures, Sera and Vaccines, Urinalysis, Tubes, Shots, Diagnostic tests charted in red ink above 103° line.

Respirations

Height and Weight

Diet

Blood Pressure

Defecation

TREATMENTS AND MEDICATIONS

		7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7
Fluid Intake 7 a.m.-7 a.m.	Oral												
	Intraven.												
	Transfus.												
Total—24 hr.—Intake													
Fluid Output 7 a.m.-7 a.m.	Urine												
	Emesis												
	Drainage												
Total—24 hr.—Output													
Signature of Nurse	7- 3												
	3-11												
	11- 7												

of the patient — of changes in his vital signs and of his physical functioning and would likewise provide a record of his medical treatment — the committee thought it should be used in conjunction with a nurse's observation record where changes in the patient's mental and physical condition, symptoms, reaction to medication and treatment, and other valuable observations of aid in the diagnosis and treatment of the patient, might be noted. Neither general nursing care nor information previously recorded on the graphic clinical record, it was thought, should be recorded on this sheet.

Because of the detail given on the graphic clinical record, the hospital authorities agreed that no nurse's observation record should be kept on chronic or convalescent patients. The Procedure Committee proposed that the observation record should be kept

BELLEVILLE GENERAL HOSPITAL

NURSE'S OBSERVATION RECORD

NAME.....

WARD..... HOSP. NO.....

DOCTOR.....

Date	Hour	Record below: Changes in condition, symptoms, reaction to medication treatment	Fluid Intake	Fluid Output

on all seriously ill, post-operative, and unconscious patients and on all patients on admission to hospital for a minimum period of 24 hours. If the patient's condition did not warrant its use, however, it might be discontinued by the nurse in charge of the ward and likewise it might be restarted at any time at the discretion of the head nurse. If the observation record should be discontinued, as in the case of chronic and convalescent patients, the graphic clinical record would be used exclusively.

AGREEMENT AND APPROVAL

Before arriving at these conclusions the Procedure Committee had consulted with the doctors in regard to the information they desired from the patient's record. The hospital superintendent was consulted concerning hospital policies and the legal aspects of records. The opinions of head nurses and staff nurses were sought. Sample record forms from other hospitals were reviewed. Embodying the expressed views of these groups, the nursing arts instructor painstakingly drafted many sample forms which were objectively criticized by the Procedure Committee. The problems and progress of the committee were reported and discussed at the regular head nurses' meetings. Finally forms were designed which had the approval of the Procedure Committee and the nursing staff. The new graphic clinical record was given to the president of the medical staff who presented it at a regular staff meeting. The doctors unanimously gave their approval for its adoption and, moreover, they complimented the nursing staff on the work they had accomplished. Permission to have the record printed was then gained from the hospital superintendent.

STAFF EDUCATION IN THEIR USE

After approximately four months' work on this project the new records were available for use. A copper plate had to be made at the printers for the graphic clinical record. As the nurse's observation record was a much simpler form it was possible to make a stencil in the hospital and to use mimeographed copies. The work of the Procedure Committee was not, however,

finished. As important and as exacting a task remained to be accomplished — the education of the staff in the use of the two new forms. Sample instructions were sent to all wards to be posted on their bulletin boards. To ensure that all staff members understood the use of the forms and the details of recording, group instruction was given at morning and afternoon reports. Much individual teaching and assistance was given to both student and staff nurses by the clinical instructors to secure the desired results.

Both of these new records have met with general acceptance and approval. Although much time and thought were spent on this project by committee members, the work was both interesting and stimulating. The teamwork that was necessary before the desired results could be achieved resulted, we believe, in better understanding, goodwill, and cooperation among hospital co-workers. We also believe that better patient care has resulted from more precise observation of the clinical picture and from the better budgeting of the nurses' time. The Procedure Committee feels satisfied with the success of its project.

Nursing in Angola

ANNE E. COPITHORNE

Starting off on a nine-day village trip in February is not considered the thing to do, as that is usually the month of our heaviest rains. However the roads could have been worse (but not much — in spots). We were driving the *Austin Pickup*. She is very easy to handle and even when we got into difficulties she did nobly.

Our first stop was at a village dispensary about 50 miles from Dondi. Arriving early Saturday afternoon, we unpacked and then Sr. Valentin (our African dispenser) and I went over to the village dispensary. There the local dispenser had 30 patients for us to visit. Some we treated and others we told to go in to Dondi Hospital for tests or necessary operations. The majority of our patients were women and children—the women mostly gynecological or obstetrical cases. Many had the same story —"We have lost 1, 2, 3 or even 6 babies at or before birth. *Please help us.*" The children had a mixture of complaints. Almost all had enlarged spleens from frequent malarial infection. Two teen-aged youngsters looked very like advanced tuberculosis cases. Just as we were finished a little two-month-old babe was brought in, gasping its last breath. Poor mothers and babies of Africa!

A graduate of the Vancouver General Hospital, Miss Copithorne has spent many years in nursing service in Portuguese West Africa.

In the evening around the campfire we had a short service and then talked about some public health problems. We had D.D.T. with us and discussed its use; then prenatal care and the need for young mothers to come for a check-up; how to prevent babies from getting sick and, if they were sick, to bring them quickly to the dispensary instead of to the native herbalist first and then, when it was too late, coming to us to see if we could perform miracles. Thus the evening went. As a finale we played some records. The people are very musical and enjoyed the gramophone.

So the days passed as we repeated this program wherever we went. The following Sunday we spent at a pastoral centre where people had gathered from all the nearby villages. Just as we were finishing lunch, word came of an obstetrical case in difficulties in a village some little distance away. We packed up and away we went — along the main road at first and then over a very poor track across country. Finally we left the car and walked the last mile. In a poor little village we found the house easily as all the villagers were outside waiting for the woman to die. Her story follows a pattern that we all know so well out here. Her first baby. She went into labor *Monday*, delivered a dead babe *Saturday* and now the placenta would not deliver. I entered the little ramshackle mud-and-stick

(*Turn to page 897*)

Aux Infirmières Canadiennes-Françaises

Plan de l'Organisation du Travail de la Directrice des Infirmières

SOEUR ST-ILDEPHONSE, S.C.Q.

D'APRES LE SCHÉMA ci-contre, la directrice joue un rôle d'une très grande importance dans la bonne marche et le progrès de l'oeuvre hospitalière tant au point de vue moral et religieux que scientifique et professionnel; ce qui implique l'instruction et la direction qui rendent l'étudiante capable d'utiliser avec le plus grand avantage les connaissances et l'expérience acquises. Par conséquent, la directrice se doit d'avoir une formation aussi élevée que ses devoirs. En définitive, c'est sa valeur qui s'irradie dans ses élèves et ainsi se diffuse dans la société. Tant vaut sa valeur tant vaut l'éducation de ses élèves.

Educatrice, elle a à développer une personnalité saine, pourvue de sensibilité, de compréhension, d'habileté et de toutes ces qualités morales, spirituelles qui procurent le bonheur personnel et celui des autres.

Si la formation scientifique de l'infirmière doit répondre aux exigences de l'état pathologique du malade, son sens humanitaire, chrétien et social doit être sensibilisé par une culture adéquate afin de capter les émotions, les réactions de ce dernier, parfois plus mentales et morales que physiques, pour les transformer en patience . . . en douceur . . . en résignation. Le malade est un être humain qui a plus besoin parfois d'attention que de médication. On voit ici que l'infirmière doit être formée en vue d'une compréhension vraie, vivante et palpable de l'humanité.

Soeur St-Ildephonse est directrice de l'école d'infirmière, Hôpital du St-Sacrement, Cité de Québec.

S'il existe une profession qui exige pour son parfait épanouissement, pour son plein exercice la pratique des plus hautes vertus, jointe à une compréhension exacte de la nature humaine, c'est bien la profession d'infirmière, qu'on se plaît à appeler: le sacerdoce de l'infirmière, vu le rôle éminemment chrétien, humain de cette femme qui se penche, compatissante et bonne sur la souffrance des hommes avec sa tête, son coeur, son âme et s'emploie à la soulager. Une telle fonction ne peut être l'effort de la directrice seule. Elle le sait et ce doit être une de ses qualités dominantes d'exploiter les valeurs qui viennent en contact avec ses élèves au bénéfice de leur formation générale, religieuse et professionnelle. L'éducation est un drame où tous les acteurs jouant un rôle particulier s'achève dans l'harmonie de l'unité.

Plan de l'organisation du travail de la directrice des infirmières.

La pierre philosophale de l'éducation est la dévotion au Saint-Esprit. L'enseignement ne trouvera jamais le chemin des coeurs s'il n'est inspiré que par une connaissance livresque. Pour être vivant, l'enseignement doit être pétri, à la fois, de bonté, d'amour et de charité chrétienne. Il doit porter le sceau de la tendresse humaine et être illuminé par la charité du Christ. C'est le coeur de la directrice qui doit parler au coeur de l'élève, son âme qui doit éclairer son âme, et le langage du coeur ne s'apprend dans aucun livre, il puise son inspiration dans celui de l'Amour débordant du Coeur de Jésus. Dans ce délicat et difficile travail d'éducation, une solide formation religieuse jointe à un grand esprit de foi et de prière s'impose.

Le jour de sa réception à l'Académie Française, Pasteur prononça ces belles paroles:

> La grandeur des actions humaines se mesure à l'inspiration qui les fait naître. Heureux qui porte en soi un idéal de beauté et qui lui obéit — idéal de l'art, idéal de la science, idéal de la patrie, idéal des beautés de l'Evangile. Ce sont les sources des grandes actions et des grandes pensées. Toutes s'éclairent des reflets de l'Infini.

N'oubliez pas, dit Riboulet, que votre influence sera en rapport avec votre valeur intellectuelle et morale. Il y a dans la vie d'un homme une heure décisive où il est appelé à donner sa mesure. Pour une directrice, l'heure est venue; à elle incombe le devoir d'être à la hauteur de sa position.

Citons Monseigneur Bougaud rendant témoignage à la première directrice, Louise Legras. Il énumère sans un style aussi précis que bref, les qualités d'une directrice d'école:

> Elle avait l'esprit juste et vif, l'âme virile presque rien de la femme que le coeur; la décision prompte et toujours si parfaite qu'il n'y avait pas à y revenir. Son esprit avait des lumières infinies sur l'intérieur des autres. Elle révélait les âmes à elles-mêmes.

En résumé, donner à sa personnalité toute la valeur qu'elle est susceptible d'avoir et la mettre au service des autres. *Mieux vaut savoir pour mieux servir.*

℞ *Chuckles* P.R.N.

Immunization is the giving of sermons to children to prevent disease.

A bruise is the breeding of capillaries under the skin.

The wastes of the body pass out through the organs of illumination.

The Schick test is to provide you with a few diphtheria germs.

The salivary glands situated under the ear are called the paranoid glands.

The most important function of the erythrocytes is to color the blood.

Serum is the liquid form of blood and plasma is the dry form.

The paranasal sinuses allow light into the head.

Dissolve some soap in warm water and whip with rotary eggbeater or mixer in a deep bowl until the suds look like thick cream. Spread mixture on the branches of the Yule tree; let it dry. Result: an indoor Christmas tree covered with a gleaming "snowdrift." For a "fresh fallen" effect, sprinkle soap flakes over the suds. The effect is a bit startling to anyone who doesn't know the trick. Best of all, the "snow" dries to a stiff finish, won't shed or fall to the ground. (No particles in the rug to clean up when the Yule season is over.)

— *Feature.*

Increased losses of nitrogen invariably accompany severe disease or injury in previously well nourished persons. Therapeutic diets must take into account the increased metabolic demands of disease and injury as well as the increased losses of nutrients from the body. Disease and injury may also result in faulty utilization of metabolites. Protein syntheses and vitamin utilization may be diminished due to liver injury such as follows infection, injury, and shock.

— THERAPEUTIC NUTRITION,
Drs. Pollack *and* Halpern.

Trends in Nursing

General Secretary Visits P. E. I.

NEVER LET IT BE SAID that the tempo of life on the lovely Prince Edward Island is slower than that of any other part of Canada — at least that is the opinion of the general secretary who paid a five-day visit in October to Charlottetown and Summerside, where she also attended the annual meeting of the Association of Nurses of P.E.I.

From the time of her arrival until her departure every minute was occupied either in addressing meetings or visiting institutions and holding special conferences. Among the groups addressed were: the boards of hospitals and women's hospital aid societies; the A.N.P.E.I.; other nursing and lay groups. The latter included representatives from the provincial government, city council, hospital boards, directors of hospitals, and women's organizations. The Central School of Nursing in rural and other areas was the topic discussed on these occasions. Considerable interest was displayed in this timely subject.

Through the Looking Glass

For the past couple of months the mirror has had its face turned to the wall but once again let us take a look to see what the press is reporting on nursing and nurses in Canada.

A Federal Department of Labour leaflet, "Emigration from Canada," carries the statement that of the 13,500 women who left Canada in each of the two years ending June, 1950, 60 per cent or 8,100 had been gainfully employed in this country. Of this number, more than 10 per cent or approximately 810 were graduate nurses. These 810 nurses who are leaving Canada yearly, mostly for the U.S.A., leave a big gap in the ranks of nursing at a time when Canada has a great demand for nurses to fill both civil and defence needs.

It is with regret that we read that the Community Nursing Service provided in Canada by the Metropolitan Life Insurance Co. for the past 42 years is being discontinued. This service has amply demonstrated the value of a combined service and educational program rendered to families in their own homes.

Times bring changing needs as pointed out by Miss Ruth Hubbard, general director of the Visiting Nurses' Association of Philadelphia, when she addressed the conference of V.O.N. district superintendents and national supervisors in Ottawa recently. The topic of the address was "Teamwork," which she called "the challenging new role of public health."

Four Canadian nursing officers have recently been posted to Tokyo and five nursing sisters have completed the paratroop course with the R.C.A.F.

The registered nurses' associations of Nova Scotia and New Brunswick initiated the winter's activities in September by holding meetings in Halifax and St. Stephen. Nova Scotia reports that qualifying examinations for student nurses will be written for the first time by first-year students at the fall sitting of the Registered Nurses' Examination.

The recently-appointed public relations secretary for Ontario has already addressed many groups of graduate nurses. Industrial Institutes were held in September under the auspices of McMaster University, Hamilton, and McGill University, Montreal.

From London, Ont., comes news of the appointment of a male registered nurse to the supervisory staff of one of the large hospitals.

The schools of nursing of the Ottawa Civic Hospital and Victoria Hospital, London, report that student enrolment has reached a new high. The 1951 graduating class of Virden Collegiate Institute, Manitoba, has contributed five of its successful grad-

uates to the field of nursing.

Health Department salaries in the city of Montreal have been increased. The recommended increases, retroactive to December 1, 1950, range from $150 to $400. New scales, each with annual cost of living bonus unchanged at $468, are: staff nurses, $1,850 to $2,550; supervisor, $2,820 to $3,150; assistant head nurses, $3,260 to $3,480; head nurses, $3,700 to $4,250.

Guidance for High School Girls

The following item taken from the Sept.-Oct. 1951 issue of *Better Health*, published by the State of Nebraska Department of Health, contains the germ of an idea that might be worth cultivating:

> *The Future Nurses' Club:* High school girls, especially in their senior year, are making serious decisions about their careers. One high school in Nebraska gives opportunities for the girls to get acquainted with schools of nursing and with the nursing activities in their area. They can find answers to their many questions concerning nursing as a career.
>
> This club was organized by the wife of the superintendent of schools. It began with six charter members. The purpose of the club, as you may have guessed, is to encourage young women to enter the nursing profession. Regular meetings are held the third Thursday in every month in the school building. Guidance materials are studied, films are shown, and guest speakers are invited to discuss questions with the girls. Visits are made to hospitals and other centres to see nurses in action. Nurse recruitment is an important problem now. High school seniors are the ones we are looking to for help in filling the ranks in schools of nursing.

Time and Motion Studies

At this time, when the Canadian Nurses' Association is making an analysis of the work of the head nurse, it is interesting to note the following comments on motion and time studies.

A committee of experts, under the chairmanship of Prof. Sir Frederic Bartlett, C.B.E., M.A., F.R.S., professor of experimental psychology at the University of Cambridge, planned an experiment to test the consistency of stop-watch time studies. The project was designed to test and compare the findings of a group of 30 experienced time-study practitioners from different industrial firms when set to assess the same operation. The results of the experiment proved indisputably that, working under laboratory conditions with variables as far as possible reduced and controlled (1) *the final time values set by the group of time-study practitioners, assessing the same operation, revealed a high degree of inconsistency* and (2) that the locus of inconsistency lay not in the basic times set for each operation, but *in the assessment of the working performance of the operator* and in the differing "allowances" made by each observer for fatigue, personal needs of the operator, company policy, and other factors.

It was, therefore, suggested to the committee that further work be pursued along two different lines. The second and much longer term inquiry will consist of fundamental scientific research into the measurement of human performance on skilled operations with the aim of evolving techniques based on scientifically valid principles to replace existing practices.—*The Nuffield Foundation, Sixth Report.*

Bridging the Gap

In an article entitled "Hospital and Home Care," the writer commented on the contribution a combined hospital and home care plan could make to the welfare of the patient. He makes the following comments:

> By coordinating the hospital medical and social services with a nursing unit which extends into the home, real progress would be made. The nurse could inspect home facilities and assess the situation in regard to convalescent care for the patient. It would not be our present "hit and miss" system which is carried out by remote control. It is my hope that one day we may develop some arrangement whereby organizations such as the Vic-

torian Order of Nurses could be assimilated into a pattern which could bring them into direct contact with the patient while he is still in hospital. There would be conferences on individual cases who are in need of expert care. In this manner, the post-hospital home visit would contribute so much more to medical progress. —*The Canadian Hospital*, Aug. 1951.

United Nations Publications

We have been notified by Miss Kathleen E. Bowlby, national secretary of the United Nations Association in Canada, that sample packets of U.N. publications are available on request to the headquarters of any interested organization. Additional supplies of any of the sales brochures can be secured from *The Ryerson Press, 299 Queen St. W., Toronto 2B.*

"Study Abroad," Volume III, is a handbook which tells where students may apply for study grants and lists the required qualifications, stipend rates, subjects, and countries of study. If not presently available through Ryerson Press, it may be secured from the *Columbia University Press, 2960 Broadway, N.Y.*, at $1.25 per copy.

New Treatment for Leprosy

Dr. M. A. K. Dalgamouni, of the Egyptian Ministry of Health, has just returned from a two-month mission in Ethiopia for WHO during which he introduced new methods of treating leprosy. Dr. Dalgamouni visited the Akaki and Harar leper colonies where he demonstrated the use of a new drug, sulfetrone. Known to be extremely effective against the disease, enough sulfetrone was left in the two leprosaria to treat 700 patients for a whole year.

Orientation et Tendances en Nursing

La Visite de la Secrétaire Générale à l'Ile-du-Prince-Edouard

Celui qui serait tenté de dire que le rythme de la vie est plus lent dans l'Ile-du-Prince-Edouard que dans le reste du Canada se verrait contredit par la secrétaire générale de l'A.I.C. Durant une visite, qui a durée cinq jours, en plus d'assister à l'assemblée annuelle de l'association provinciale, Mlle Hall a été occupée dès l'instant de son arrivée jusqu'à la dernière minute de son séjour. Elle a adressé la parole à diverses assemblées. Elle a visité plusieurs institutions et a donné des conférences à des groupes spéciaux tel que directeurs d'hôpitaux, dames patronnesses, infirmières, représentantes du gouvernement provincial, du conseil de ville. "L'Ecole d'Infirmières Centrale" a été le sujet dont il a été question. L'on a montré beaucoup d'intérêt.

Coup d'Oeil Ici et Là

Depuis une couple de mois nos yeux se sont plutôt tournés vers les paysages riants des endroits de villégiature plutôt que vers le nursing. Voyons ce que la presse, à travers le Canada, dit de nous.

Le Ministère du Travail vient de publier un feuillet intitulé "Emigration de Canadiens." L'on y lit que 13,500 femmes sont parties du Canada durant les deux dernières années, soit à la fin de juin, 1950. De ce nombre, 8,100 retiraient un salaire et plus de 10 pour cent de ces femmes, soit environ 810, étaient des infirmières diplômées. Ces 810 infirmières qui annuellement quittent le Canada, se rendant pour la plupart aux Etats-Unis, causent un grand vide dans les rangs des infirmières canadiennes, particulièrement à ce moment où l'on prévoit qu'un grand nombre d'infirmières sera nécessaire pour répondre aux besoins de la population civile et à ceux des forces armées.

C'est avec regret que nous avons appris que le service d'infirmières visiteuses de la Compagnie d'Assurance Vie Metropolitan sera discontinué après 42 années d'existence. Ce service, combiné de soins aux malades et d'éducation en matière de santé, donné directement à la famille a démontré la valeur de ce système.

Tout change avec le temps comme le faisait remarquer Mlle Ruth Hubbard, directrice de l'Association des Infirmières Visiteuses de Philadelphie, aux surveillantes des districts du V.O.N., réunies à Ottawa. Le sujet de sa conférence "Un Nouveau Défi Lancé à l'Infirmière Hygiéniste" expliquait le travail d'équipe en nursing.

Quatre infirmières de l'armée canadienne sont parti récemment pour Tokyo et cinq autres ont complété leur cours de parachutistes avec le R.C.A.F.

Les infirmières des associations de la Nouvelle-Ecosse et du Nouveau-Brunswick ont repris leurs activités de l'hiver en tenant une assemblée à Halifax et l'autre à St-Stephen. L'on rapporte en Nouvelle-Ecosse que les examens d'enregistrement après la première année se tiendront pour la première fois.

La secrétaire, nommée récemment en Ontario pour s'occuper des relations extérieures, a parlé à un groupe d'infirmières à Barrie. Des journées d'étude pour les infirmières des industries eurent lieu à Hamilton sous les auspices de l'Université de McMaster et à Montréal sous les auspices de l'Université McGill.

De London, Ont., la nouvelle nous parvient qu'un infirmier (male registered nurse) a été nommé surveillant dans un service d'un grand hôpital.

Les écoles d'infirmières de l'Ottawa Civic Hospital et du Victoria Hospital, London, rapportent que le recrutement des élèves est très élevé.

Le salaire des infirmières du Service de Santé de Montréal a été augmenté. La recommendation, qui avait été faite d'augmenter les salaires de $150 à $400, a été rétroactive à partir du premier décembre, 1950. Le boni de vie chère à $468 demeure le même. Le barème de salaire est le suivant: infirmière en service général, $1,850-2,550; surveillante, $2,820-3,150; assistante directrice, $3,700-4,250.

Orientation pour les Etudiantes

Une idée qui pourra donner naissance à d'heureuses initiatives nous est rapportée du Nebraska. Le Ministère de la Santé de cet état, dans une revue intitulée *Better Health*, rapporte que des dames ont formé des clubs pour les étudiantes de dernière année de ces écoles. C'est durant cette dernière année de leur cours que ces jeunes filles doivent prendre une décision concernant leur carrière et c'est durant cette année-là qu'il semble opportun de les renseigner sur le cours d'infirmière. L'on s'efforce lors des réunions des membres du club de répondre à toutes les questions posées sur le cours d'infirmière. L'on y montre des films, l'on fait des visites aux hôpitaux, etc.

Temps et Mouvement

Il est intéressant de noter au moment où l'A.I.C. fait une étude sur le temps et le mouvement dans un hôpital d'Ottawa, les remarques faites par le professeur de psychologie, Sir Frederic Bartlett, de l'Université de Cambridge.

En examinant les rapports de 30 études sur le temps et le mouvement, faites en industrie par des techniciens expérimentés sur la même activité, l'on constate une grande différence d'appréciation. Différents facteurs, tel que la fatigue, la politique adoptée par l'industrie, etc., semblent la cause de cette différence.

Pour Combler les Lacunes

Dans un article du *Canadian Hospital* du mois d'août, 1951, sur "L'Hôpital et Soins à Domicile" l'auteur énumère tous les bienfaits d'un service hospitalier qui s'étend jusqu'au domicile du malade. En coordinant le service médical à l'hôpital avec le service social et avec un service d'infirmière visiteuse à domicile l'on réalise de grands progrès. L'infirmière peut visiter le domicile du malade pour voir si les conditions favorisent son rétablissement. Elle peut aussi visiter le malade à l'hôpital, apprendre de l'hospitalière des besoins, etc.

Nations Unies et Leurs Publications

La secrétaire de l'Association des Nations Unies au Canada nous fait savoir qu'un colis échantillons des publications des Nations-Unies peut être envoyé sur demande au bureau d'organisations intéressées. Pour se procurer des exemplaires supplémentaires des brochures publiées par les N.U., écrire à *The Ryerson Press, 299 Queen St. W., Toronto 2B.* "Study Abroad," Volume III, est un manuel contenant une foule de renseignements pour les étudiants qui veulent étudier outre-mer; ou s'adresser pour obtenir la liste des bourses d'études, des prêts; les qualifications requises; les appointements à verser aux professeurs; les matières à étudier dans tel pays, etc. L'on peut se procurer ce livre en s'adressant à *Columbia University Press, 2960 Broadway, N.Y.*— $1.25 par exemplaire.

Un Nouveau Traitement de la Lèpre

De retour d'un voyage de deux mois en

Ethiopie, le Dr. M. A. K. Dalgamouni, du Ministère de la Santé d'Egypte, a visité pour le compte de l'O.M.S. deux léproseries où il a donné une démonstration sur l'usage d'un nouveau médicament très efficace contre la lèpre: "le sulfetrone." Une quantité suffisante de ce médicament pour traiter 700 malades a été laissée aux deux léproseries.

Flowers are Beautiful

VIOLA ROBERTS

DECEMBER MARKS the beginning of winter in our climate. The riot of color in our gardens was blackened weeks ago by heavy frost. Only a few people are fortunate enough to have their own private greenhouses where they can still revel in the luxury of cutting their own blooms as and when they please. For most of us, cut flowers and house plants from our nearby florist are the order of the day. It seems an appropriate time, therefore, to give some thought to the care of these precious blooms so that they may continue to give pleasure for as long as possible.

Some cut flowers just naturally last longer than others. Chrysanthemums are noted for being long-lasting. With proper care they should still be presentable after two weeks. Roses, carnations, snapdragons, tulips, and stocks should last almost a week. Don't expect sweet peas, freesias, pansies, or daffodils to last that length of time. You will enjoy the beauty of their individuality for only a few fleeting days.

How can you extend the life of these blooms to the fullest? Chrysanthemums and other heavy, woody-stemmed flowers absorb water better if the stems are broken, split up a few inches, or crushed slightly. Flowers which "bleed" after they are cut, such as poinsettias, hydrangeas, poppies, and heliotropes, should have their stem ends seared over a flame, with hot water or a hot iron. When poinsettias are used as cut flowers, the stems should be sealed by dipping the end immediately into boiling water and allowing the water to cool with the stems in it. This stops the "bleeding" and saves the strength of the flowers. Daffodils, calla lilies and other flowers with water-filled stems do not need deep water in their containers. The hairy stems of zinnias and poppies should be singed slightly.

Never let flowers lie around out of water as the stems seal themselves which interferes with their ability to absorb water. Flower stems should never be cut with scissors which crush the stem tissues. A sharp knife should be used to make a long slanting cut. The stems should be cut this same way every day. Never let any of the foliage come below the water level for the leaves will decay and foul the water.

Always keep your vases and flower containers immaculately clean. A dirty container will shorten the life of the flowers. Another good rule to follow is not to crowd too many blooms into one container. Besides bruising the flowers, it makes an unattractive arrangement.

FLOWER ARRANGEMENTS

An artistic flower arrangement conveys so much more beauty and joy than a bouquet carelessly stuck into a vase. Creating an artistic arrangement is an art but not too difficult for an amateur to acquire. All that you need, really, is to apply basic principles to *your* flower arrangements, then add a little imagination.

There are three types of arrangements: *modern*, including line, cres-

This informative material is made available through the courtesy of the Society of American Florists.

cent, and curving arrangements; *traditional*, including massed and colonial arrangements; and the *oriental* or *symbolic* arrangement, the highest blooms symbolizing heaven, the middle height for man, and the lowest for earth.

Flowers with curving stems — such as petunias, daisies, sweet peas, and tritomas — are excellent for crescent and curving arrangements. The straighter-stemmed flowers, such as carnations and chrysanthemums, are popular for line and oriental arrangements. Dominant flowers, such as chrysanthemums, dahlias, and peonies, are suggested for massed arrangements. Delicate flowers, such as delphiniums and sweetheart or garnette roses, are ideal for colonial designs.

For any of the arrangements, you'll need various working materials — suitable container, scissors, knife, stem holder (needle holder, frog, or small mesh chicken wire), putty or suction cups (if heavy flowers are used) to make the stem holder stationary, thin wire and wire clipper.

The triangular design: Amateurs usually want to learn how to create triangular arrangements. For this design, the longest stem should be one and one-half to two times the height or width of the container. Insert the backbone of the design first, then fill in with the shorter-stemmed flowers to fill in the sides. No two stems should be the same length. The largest and darkest flowers are used for the base of the design and centre of interest. The buds and smallest flowers are for the outermost points of the design.

Don't mix too many fragrances in a bouquet. For instance, roses, gardenias, and carnations all have lovely fragrances of their own. Don't use too many colors in one arrangement — two or three are enough. Remember to group your colors instead of spotting them throughout your arrangement.

There should be no crossing of leaves or stems. Each leaf, stem, and flower plays a definite part in the design. If flowers do not have distinctive foliage of their own, use other leaves, such as croton, sansevieria, dracaena, magnolia, caladium, and evergreen.

The completed arrangement should have all the essentials of good design — unity, rhythm of lines, proper proportion, balance, color harmony, and centre of interest. By using one of the commercial preparations in the water to lengthen the life of the flowers, you will avoid having to change the water every day. As soon as the lower blossoms of spike flowers (gladioli, delphiniums, snapdragons, stock, and others) become wilted, they should be removed, the stems shortened, and the arrangement kept unified. Never place an arrangement in a sunny window, draft, or on a mantel over a burning fireplace, or near a radiator if you want it to stay pretty for long.

Your arrangements will be more interesting if you use figurines, leaves, fruit, or gourds to suggest the spirit of the season or to portray a mood or theme.

Care of House Plants

When to water a plant is often a problem for amateurs. You may test the dryness of the soil by tapping the outside of a clay pot with a pencil or your knuckles. If it makes a dull sound, the soil is still moist. If there's a sharper, hollow sound, the pot needs watering. You can also tell if it is dry by crumbling the soil with your fingers.

Foliage plant roots will be much healthier if they are watered only when they need water. However, they must never be allowed to dry out. When you water your plants, water them thoroughly with tepid water, not just on the top. Do not let surplus water stand in the saucer under the pot for more than an hour. The plant has all the water it wants and the surplus water will just make the soil soggy and perhaps rancid.

Plants need less water on cloudy days than on sunny ones. They also dry out more quickly in the summer than in the winter.

Foliage plants usually require water only about twice a week unless their pots are small. Blooming plants re-

Step 1 in arranging flowers is to insert the stem holder. Small mesh chicken wire is being used here.

Step 3—The longest stems form the basis of the triangular design with shorter-stemmed, larger flowers for the sides and lower part.

quire more water. Plants with thin leaves, such as caladiums, often need more water than the thicker leafed ones like sansevieria.

Keep your plant leaves clean. This means spraying the foliage plants or going over each one with a moist cloth. A soft camel's-hair brush, such as a soft paint brush, is suggested for brushing the hairy leaves (African violet, gloxinia, etc.) to clean them.

Don't let a hard crust form and stay on the top of the plant soil because it keeps out the air. Use a fork or similar article to loosen the soil but don't push it more than a half an inch deep.

Water your plants in the morning so they may have the entire day to drink up the water. Don't let them "go to bed" with "wet feet."

In removing a plant from a pot, be careful not to injure its roots. If the ball of earth is moist, the roots won't cling to the side of the pot.

Step 2—All foliage must be removed which might come below the water level. Cutting the stem ends diagonally helps them to absorb water.

Step 4—The arrangement has all the essentials of design—unity, balance, proper proportion, rhythm of lines, centre of interest, and color harmony.

Spread the fingers of your left hand around the plant and to the rim of the pot. Then invert the pot and tap or knock the top edge of it against the end of the table until it drops out into your hand. Sticking a table knife down the inside edge of the pot will loosen the soil if it is too stubborn. In repotting the plant and adding fresh soil or potting mixture, be sure to leave enough space at the top for water. The soil should be neither too loosely nor too firmly packed. Transplant only in the spring or fall, if a plant needs repotting. It is usually best to shift plants to pots just a size larger than their present ones.

Keep most blooming plants in sunny windows. Begonias and African violets thrive in east or north windows on little or reflected sun.

Turn your plants around every few days, so that all sides of the plant may have a chance at the sunlight for even growth.

The chrysanthemum is one plant which may lose its leaves before it finishes blooming. By spraying the leaves with water every day, they will not turn brown so quickly.

In washing foliage leaves with soapy water, use a mild soap or flake soaps. This discourages scale, mealy bugs, mites and other insects.

Plants have periods of rest, the same as trees do. Often when plants appear to be dying, they really are only resting.

A few plants which like a warm, humid atmosphere are: peperomia, maranta, caladium, poinsettia, nephthytis, African violet. Rose plants need continual moistness, sunshine, and coolness. Gloxinias need humidity, even dampness, with watering from below, no sun after mid-morning, and the leaves should always be dusted instead of sprayed with water. The azalea has such fine and delicate roots that it suffers easily from both dryness and over-watering.

Dead leaves, stems, or blooms should be removed promptly as they rot the living tissue they touch.

Never use cold water for watering your plants. Slightly tepid water is much better. This is especially important with African violets.

New Student Nurses' Residence

In Vancouver last December, just one week before Christmas, a group of 162 excited young women packed their trunks and suitcases in preparation for a pre-Christmas journey. They were student nurses at the Vancouver General Hospital and they were readying themselves to move into their new quarters. The newly-completed first unit of the Hospital's nine-storey student nurses' residence, when completed in early 1952, will provide accommodation for 575 student nurses.

Nearing completion, Fall of 1951.

The Hospital's school of nursing recently received an application from a young woman lucratively employed as head teller in a bank. She explained that she had been thinking about entering nursing for some time and added that the new students' residence was "an irresistible lure."

Certainly the new residence has special attractions. From the spacious entrance to the attractive solarium and sun-deck atop the eighth floor, nothing has been overlooked for the student nurses' comfort and convenience. The main floor of the new residence contains administration offices, two large reception lounges, four conversation rooms (dubbed "beaux rooms" because the cozy rooms have leatherette doors that do not quite close), a

The sun-deck

Corner of the lounge

library and a reading room, and a large attractively appointed ballroom. The effect throughout is one of restfulness and quiet good taste. In the lounges, finished in a hardwood veneer with mirrored columns, the modern furnishings are arranged in artistic "conversational groups."

A feature of the lounges that has attracted considerable attention is the art. Paintings by well known Canadians are shown on a rotating loan basis. It is a frequent thing to see groups of students and their visitors gathered around a certain painting, discussing its meaning. "We may not understand the paintings but we certainly do appreciate them," declared one student nurse.

Credit for the attractive and refreshingly different interior decoration on a British Columbia motif is due to the Decoration Committee, convened by energetic Mrs. Ernest T. Rogers, R.N., a member of the Hospital's Board of Trustees. "We feel," said Mrs. Rogers, "that our efforts were repaid when we first heard a visitor exclaim: 'Golly! I think I'd like to be a nurse!' The expression is becoming a familiar one in Vancouver."

Donations by organizations and individuals have added to the student nurses' comfort. Especially noteworthy was a $1,000 gift for library books from the Training Schoo [Committee of the Women's Auxiliary.

The ballroom, used for dances, receptions, other ceremonies and social functions, is soundproof, featuring a new type of "acoustic plaster" ceiling. A fully-equipped kitchen adjoins the ballroom and a moveable platform and a piano are added for concert purposes.

Basement of the new residence — at ground level — is both utilitarian and attractive, with a large recreation room for table-tennis and other indoor games, a sewing room, trunk and

Vancouver Sun photo

Getting ready for Christmas

Vancouver Sun photo

Students' laundry

Corner of a bedroom

bicycle rooms, and space for a future beauty parlor.

Four self-service elevators lead to the six residential or sleeping floors. Quick moving and smooth riding, the elevators are each equipped with an electric "magic eye" that prevents the doors closing on anyone.

Each of the residential floors in the first unit has 27 single bedrooms compactly furnished and decorated in a variety of pastel shades. Curtains and drapes blend harmoniously with the natural-finish furnishings. Each room has a house phone on which the student nurse can receive outside calls directed from the matron's office on the main floor. For outgoing calls there are telephone booths on all floors.

On each floor are two compact laundry rooms for the students' personal laundry. They are equipped with automatic washers and driers and ironing boards. The bulk of the students' washing is done in the hospital's main laundry. Each floor also has a small lounge with an adjoining kitchenette for between-meal and evening snacks. Regular meals are eaten in the main nurses' dining hall.

Construction of the second and third units — the north and south wings of the main structure — was started in November, 1950. When completed in early 1952, these units will accommodate another 413 student nurses.

Priority on occupancy of the first unit went to senior and second-year students. Probationers and juniors are presently accommodated in the recently renovated "1914 Home."

Saving Sight of Desert People

(*Continued from page 869*)

projected five years ago as an offshoot of the general hospital in that city. Its cost of upkeep is borne by the Saudi Arabian government. Much of its equipment was a gift from the United Kingdom government. In charge of it is an eye specialist from Britain; helping him as nurses are local Arabs.

Opened in April, 1950, the Jedda Ophthalmic Hospital has already become well known far beyond the city. In the first year of its work nearly all its patients came from Jedda and the district round about. This year nearly half of its patients have come from other parts of Saudi Arabia. They arrive by car and by camel; by bus and by boat. They come through subscriptions raised in villages to send a number of villagers together for treatment. They walk vast distances. Patients come to the hospital from as far as Bahrein Island — over 800 miles away.

The eye disease, trachoma, is widespread in the Middle East — perhaps not as common in Saudi Arabia as in some neighboring countries, but still very prevalent. It leaves behind a weakness which makes the sufferer an easier target for other eye troubles. The old Arab method of dealing with cataract, known as couching, was sometimes quite successful — it still is occasionally — but all too often it failed or left behind weaknesses which allowed infections into the eyes.

The United Kingdom doctor who founded the hospital has become famous throughout Saudi Arabia for his cures of trachoma and cataract, as well as trichiasis and the severe conjunctivitis common in those parts. His success is due not only to his skill but also to the excellence of the equipment in the hospital. Its standard is equal to that of any other eye hospital in the Near and Middle East and comparable to that of any hospital of similar size in the world.

Under the new Saudi Arabian Health Minister it is probable that the Jedda Ophthalmic Hospital will be expanded. At present it has, officially, 25 beds. Because of the pressure of patients, however, it rarely houses less than 45. It is an Arab custom for a patient to take to hospital with him two or three of his closest relatives. This is quite a good arrangement for it means that these relatives will

assist in the nursing — and they have due regard for the patient which is an essential of good nursing.

The eye specialist is the only British subject in the hospital. He has trained local Arab boys as nurses and they are extremely good at this work, having the patience and the intelligence required as well as the proper feeling for the work. In charge of the nursing in the women's part of the hospital is a local Arab woman who has also been especially trained.

In the last 12 months over 5,000 patients have been treated at the hospital. Of that number over 1,000 needed major operations. When the eye hospital was part of the general hospital at Jedda the largest number of eye operations performed in one year was 400. The separation of the two institutions brought great responsibility in the big increase of patients. It can be hoped that the cooperation which brought about its establishment will help it to a successful future.

Nursing in Angola

(*Continued from page 884*)

hut, about 7 feet long by 4 feet wide.

The patient, a young woman, was lying on a mat made of bamboo sticks and over her was a rag of dirty blue cloth. At her feet lay the little dead baby, still attached to her mother by the placental cord. Close beside the sleeping mat was a tiny smoking fire and there were a few cooking pots in the corner. There was lots of light in the hut coming in through the holes in the wall.

I asked for a basin, soap, some boiling water and some rags. "We haven't any," was the reply. I got up off my knees from beside the patient and went outside and then blew up! The truth was that the people were afraid to do anything for her because she was in difficulties as "a punishment for immorality." That was their explanation of the difficult labor. Anyone who helped her might be the one who got her into difficulties and, if not, the helper would be herself in difficulties later. Fear, and its power over life and death in Africa, is something that we will never completely understand. Finally, a fire was lit, someone went to the river for water, a basin and soap were produced. After more delay two rags were found. They turned out to be two badly worn socks belonging to the village chief!

While waiting for the things to boil I went back in to the patient and asked her about food. She had had nothing to eat or drink for six days. Again I went out and demanded *ocisangua* (a favorite drink made from corn). "We haven't any" was the chorus. Once again I blew up — enough to overcome their fear of helping the woman. I wanted a pint of ocisangua *immediately*, and it was produced. The poor soul drank it down without stopping for breath. With the boiled rags and boiled water I then cleaned up the patient as well as possible. After a good wash, I examined her to see if by any chance the placenta was in the vagina. The patient had been mauled about quite a bit by would-be African helpers and she was very edematous. I found that the placenta was still attached, so I cut the cord with a dirty rusty knife that I had boiled, used the freshly boiled socks as perineal pads, and told the folk outside that we would have to take her into the hospital.

There didn't seem to be any decent cloth to cover her while carrying her to the car. I saw some rags of a blanket hanging on the wall. Use that! — "It's *chamales*" (someone else's) was the answer. I didn't care whose it was and said so rather forcibly. So it was used to cover our poor little patient and away we went to the car.

Back at Dondi Hospital, the patient rallied very well although she may not be able to have any more babies. That is a complete tragedy in African life. The wife who has no children can be cast off like a discarded rag.

When one thinks of all the poor young mothers who do not get to hospital and who suffer and die in the villages for lack of the simplest care and treatment, it makes one realize how appalling is the need for more doctors and nurses to teach our African men and women how to look after their own people.

People on the Pacific Coast annually consume 22 lb. of butter per capita; in the Southern States only 8. Butter was Napoleon's favorite food; he often made a meal of it. Butter is rich in vitamin A — especially rich in carotene, which aids sight. Ten and a half quarts of milk yield a pound of butter.

— *Feature.*

Student Nurses

Hyperparathyroidism

BETTY HENDERSON

Average reading time — 6 min. 6 sec

ON THE AFTERNOON of January 17, Mr. Cathcart, a small man, 35 years of age, was admitted, walking, to the hospital ward. Although not acutely ill on admission, he had a history of five years' illness. He had been brought in for observation and treatment. The family history of the patient revealed nothing of significance relating to his condition.

The first symptoms he had had, previously, were nausea and vomiting with pain radiating through the lower left quadrant. This attack had lasted two months. He had been admitted to the hospital when his weight dropped to 90 pounds. His joints were all painful and swollen and during his hospitalization he passed seven small kidney stones. Since that time he had passed approximately 15 stones.

During the intervening years recovery was not complete. Joint pains were felt and he generally seemed weak. Although feeling better than usual, recently, he had never completely regained his health. Two and one-half months prior to the present admission, Mr. Cathcart suffered an acute pain in his left side. He felt a stone migrate through the ureter. Once in the bladder it was passed without difficulty. This brought marked relief and, apart from weakness, he had no other symptoms.

Mr. Cathcart was a laborer. He had apparently worked hard to support his wife and children but had succeeded in maintaining only an average standard of living. His family relationships seemed to be happy, influencing his health only for the good. He was by nature a quiet, cheerful person and seemed very anxious to cooperate in every possible step which would lead to his ultimate recovery.

Following his admission, physical examination revealed: heart, lungs, joints and extremities, eyes — normal; abdomen — normal, no tenderness; neck — tenderness in the region of the thyroid gland. This, along with the past history, gave the doctor the clue to nephrolithiasis or nephrocalcinosis. This provisional diagnosis was borne out by x-rays of the kidneys revealing diffuse calcification in both. The Sulkowitch's test of the urine showed a marked increase in urine calcium. Urinalysis indicated the presence of blood and many pus cells. A later examination of the blood revealed an abnormally high calcium level.

Reports on blood work carried out on January 25 and March 22 showed the following:

Serum calcium — 14.4 — 19 mgm. % (normal 9.5-10.5 mgm. %).

Serum inorganic phosphorus — 2.1 mgm. % (normal 2.5-4 mgm. %).

Alkaline phosphatase — 3.4-5 units % (normal 2-8 units %).

These findings indicated hyperparathyroidism in which there is an abnormally high blood calcium, leading to the formation of kidney stones composed of calcium phosphatase, as a result of an abnormally high concentration of these elements in the urine. This particular case differed from most cases of hyperparathyroidism in that the high blood calcium did not occur at the expense of the calcium of the bones, which remained hard and unaffected.

Mr. Cathcart was transferred to surgical care on March 31 for an exploratory operation of a possible parathyroid tumor or growth. The desired effect of this operation is, by surgical

Miss Henderson was an honor student in this year's graduating class from the Moncton Hospital, N.B.

removal of sufficient parathyroid tissue, to permit the return of calcium and phosphorus metabolism to normal. The patient had been built up for this operation by the injection of Beminal 1 cc. daily; a low calcium diet; and phenobarbital gr. 1 at bedtime for sleep. The only other drugs given during this period were Penicillin 400,000 units b.i.d. for 12 days during which time he had a cold; and Frosst 222 (one tablet), for general discomfort, as necessary.

On April 4, Mr. Cathcart was taken to the operating room for a parathyroidectomy under general anesthesia. Only two of the four parathyroid glands were removed, thus leaving sufficient for normal function.

Post-operatively the patient was watched closely for any signs of twitching or muscle spasm, which would indicate tetany resulting from parathyroid hypofunction. In this respect, however, he had no complications. After the first few days he was given a normal diet and permitted to feed himself. General nursing care for surgical operations on the neck were carried out, with special attention given to any signs or symptoms which would indicate complications. Morphine sulphate was given q.4 h. as necessary for pain and discomfort. Four days post-operatively skin clips and the drain were removed and after one week the patient was allowed up. During this period, hoarseness of the voice was quite evident but soon lessened, thus showing there had been no damage to the recurrent laryngeal nerve.

The blood tests on April 11 revealed decreased calcium and phosphorus levels, although they were still above normal limits. Urine examination showed decreased calcium content, a few blood and pus cells. Mr. Cathcart's general health seemed much improved with a body weight gain of six pounds.

On April 21, a happy, contented patient was discharged from the hospital, eager to return to his family.

Although the prognosis on discharge seemed most favorable, the element of remission cannot be entirely overlooked.

An Appreciation

MARION MACVICAR, B.SC.N.

Average reading time — 5 min. 36 sec.

ONE DAY not long ago we nurses visited a class for the hard-of-hearing at Lord Roberts School. We very much admired the teacher who taught them to lip-read and acquire the skills which would help them find their place in life. Perhaps the thing that impressed us most was the spirit in which they were being taught. This spirit was summed up on the blackboard before them in the words — "Privilege leads to responsibility." Although these children were handicapped they were being helped to realize the privilege that was theirs because of the training they were receiving and in turn the responsibility to which it lead.

It seemed to me as I watched the class that the same sentence applied to me and to all of us student nurses on the eve of our graduation. It is doubtless the feeling of the class and those who have come to see us graduate, that we are, indeed, privileged and that acceptance of our privileges leads to responsibility. Let us consider a few of our privileges, that we may express appreciation for them and at

Miss MacVicar, who was a member of the 1951 graduating class of Victoria Hospital, London, and the University of Western Ontario School of Nursing, presented this Appreciation at the graduation exercises.

the same time may more readily see the responsibilities which ensue.

We come from privileged homes. It is mainly due to our family life and early care that we were able to meet the mental and physical health standards which our three years of training demanded. It was mainly due to our homes that we had the incentive and courage to develop our capabilities and thus make our lives more useful. It is due to the sacrifice on the part of our parents that we were able to spend at least three years in further education. We are grateful for the privilege of good homes.

We have been privileged in the type of nursing education we have received. We are grateful to our instructors, the doctors, and nurses who have provided us with the essential knowledge and skills. We are very grateful, though the aches, pains, and joys of student days are scarcely over. As John Fisher wrote, "The words, Registered Nurse—behind them are a hundred thousand beds made . . . acres and acres of backs rubbed, a mile of thermometers read and charted."

We are privileged in that we are graduating from a school of nursing with high standards. These standards not only influenced our nursing education but will determine to a large extent our future status in the nursing profession.

We are privileged in the friendships we have made. If friendships grow rich with the sharing of joys and sorrows then a nurse's should be doubly rich. Residence life provides both sympathetic shoulders for tales of woe and ready ears for happy news and choice bits. Shall we ever forget — our first scrub in the operating room? the quite frequent proddings to keep us awake during lectures? the fear of being caught on a midnight feast? the sudden sensation on receiving the note "Your presence is requested in the Nursing Office."

After working as one little cog in the mighty mechanism of hospital routine, which in many ways is a most satisfying experience, it is reassuring to return to residence and there regain one's individuality with friends and appreciate anew the profound significance of close human relations.

These—homes, education, friends—are only a few of our many privileges. Many, indeed, when compared to our hard-of-hearing friends. If their privileges lead them to responsibility, to what great responsibilities do our privileges lead us?

As graduate nurses our responsibility will be for the well-being of our patient. Adequate care, whether preventive or curative, involves standards of skill which can never be too high. We have thus far participated in the high standard set by our school of nursing. It is our personal responsibility now to keep our skills at the same level.

Regardless of the perfection of our technique it would be comparatively useless were it not accompanied by an equally high standard of professional ethics. Nursing ethics may sometimes appear to us to be high flown and impractical but in reality these principles are guides to the fulfilling of our responsibility. For instance, the rule that a nurse does not become emotionally involved in a situation is a sound one — if a nurse were to give way to her emotions her technical skill would be of little use in the treatment of her patients. Although ethical behavior is not always clear-cut the good nurse has a high code of personal ethics which she maintains and for which she must be willing to accept responsibility.

In view of our professional privileges then we have two prime responsibilities: maintenance of a high standard of nursing technique and full appreciation of the ethics of our profession.

Many fields of nursing are open before us. We appreciate the opportunities which these afford and realize our responsibility to choose as wisely as we can which field we shall enter.

Earlier I mentioned the privilege of having parents who, through our early years, guided us in our growth, their main hope being that we might develop personal adequacy and responsible independence. Likewise, our nursing educators have guided and

instructed us through the three years in the hope that we might gradually attain professional proficiency and responsible independence.

So, as we graduate, fully appreciating the privileges which have been ours in the preparation to become registered nurses, may we realize that "R.N." might well mean *Responsibility Now.*

Book Reviews

The Bases of Human Behavior — A Biologic Approach to Psychiatry, by Leon J. Saul, M.D. 150 pages. J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1951. Price $4.75.

Reviewed by Elizabeth Cleland, Supervisor of Psychiatric Nursing, Westminster Hospital, D.V.A., London, Ont.

This text is concerned with the psychologic and biologic forces of man. It is a representation of the mind and body as two closely related aspects of a single phenomenon — the human organism.

The book is divided into three parts. Part One deals with the newer trends in medical teaching and practice — that is, the integration of psychodynamics in the prevention and treatment of the ills of mankind. It is forcefully brought out that the understanding of human nature is basic in bringing to the individual and the community a degree of health which makes for successful living. The quotations from Sir William Osler are very apt.

In Part Two, Dr. Saul brings into still clearer focus the importance of psychosomatic medicine. Explanation is given as to how the emotional forces can alter the physiologic balance to cause physical symptoms, which may go on to produce actual changes in the structure of an organ. Conversely, physical

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illness does give rise to emotional stress in varying degrees. In essence, it demonstrates that patients are not just cases of this and that. They may have emotional and environmental problems which should be recognized and understood.

In Part Three the subject matter becomes more complex. The structure and development of the mind is analyzed in a way that brings a clearer understanding of this intricate subject. The illustrations given in clarification are exceedingly well chosen. However, there is danger of Freudian concepts being wrongly evaluated by those with limited knowledge in this field. Dr. Saul writes with great conviction of the need and possibilities for educating man to understand the emotional forces within himself in order that they may be directed into channels of mature thinking and feeling that would reduce or eliminate man's hostility towards man.

This book gives an understanding of human behavior that the psychiatric nursing texts, as a rule, do not give. The knowledge given fills in a lot of gaps — gaps that must be bridged if we are to practise psychosomatic nursing. The comprehensiveness and timeliness of the text should be of benefit to all teachers in nursing. For the student nurse, elementary psychology and sociology would be necessary links in preparation for this advanced study.

The Nose, Ear and Throat for Nurses and Dressers, by Michael Vlasto, M.B., B.S., F.R.C.S. 214 pages. British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 4th Ed. 1951. Price $1.75.

Reviewed by Marjorie Middleton, Nursing Arts Instructor, General Hospital, Medicine Hat, Alta.

The first chapter of this book entitled In the Out-Patient Department sets the scene for the whole book. It is written not so much for the bedside nurse as for those working in this department or in the operating room. The stress is on surgery. Medical treatment is briefly mentioned; actual nursing care is described more fully. The duties of the nurse in assisting the surgeon with each procedure, and the instruments needed, are given in detail.

Each section is preceded by an anatomy and physiology review. The most frequently found abnormal conditions of the part and the treatment of them are then discussed.

The book is well illustrated. Each special instrument mentioned is shown and the ana-

tomy illustrations and diagrams are clear and well labelled. There are 81 instruments pictured and 51 other figures.

The book is concisely written, easy to read and understand. Within its scope it could be a useful reference text.

Text-Book for Nurses — Anatomy, Physiology, Surgery and Medicine. Revised by J. A. Nixon, M.D., and Sir Cecil Wakeley, D.Sc. 698 pages. Oxford University Press, 480 University Ave., Toronto 2. 7th Ed. 1948. Price $6.00.

Reviewed by M. Blanche Anderson, Instructor of Nurses, City of Sydney Hospital, N.S.

This is a text written for nurses by medical doctors and is somewhat comparable to a series of lectures on the subjects included.

The introduction indicates a nice perception of the function and educational needs of the nurse of today and this understanding is shown throughout the book.

The expressed purpose of the authors was to produce a relatively short, and inexpensive, study and reference handbook which would present the underlying principles of medical and surgical treatments, a knowledge of which is essential to the nurse in her work. This purpose has been achieved.

Nursing care is only occasionally indicated. Nursing procedures are not included. There are three main sections: Section I covers the field of anatomy and physiology. Though not well integrated in parts, the presentation is clear and understandable. Not very well suited to the young student nurse it is satisfactory within the terms of reference of the book. Sections II and III deal with surgical and medical aspects respectively. The coverage is broad but uncluttered with wordy detail.

Some minor treatments mentioned are not used in this country but that does not detract from the value.

Good paper, clear print, and many excellent illustrations all contribute to the value of the book. The text is notable throughout for unusual clarity and precision of presentation. It should find a place in any school of nursing library as well as in the small group of books each graduate nurse should keep at hand.

The Red Cross Nurse in Action (1882-1948), by Portia B. Kernodle. 524 pages. The Musson Book Co. Ltd., 103 Vanderhoof Ave., Toronto 17. 1949. Price $6.50.

Reviewed by G. V. Adair, Asst. District Supt., Ottawa Branch, Victorian Order of Nurses.

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The American Red Cross nurse has been an outstanding figure throughout the years. The nursing service began less than ten years after "trained" nursing existed in America. In reading one can follow not only the history of the American Red Cross Nursing Service but also the history of American nursing. Such names as Clara Barton, the first director of the Red Cross Nursing Service, Jane Delano with her ideals of "service to humanity" and "service to country," Clara Noyes, Adelaide Nutting, Lillian Wald, Fannie Clement, Elizabeth Fox, Mary Beard, and many others live in the pages of this history.

The book is divided into six parts, each part filled with factual information concerning the development, service, and history of the American Red Cross. We see the Red Cross Nurse as a public health nurse, as a teacher of home nursing, administering the service, serving in times of disasters — fire and flood, during three wars, and in foreign lands bringing help and relief to ravaged countries.

The American Red Cross Nursing Service has played a major role in the development of public health nursing. Starting in the rural areas we see the nurse in the early years of the 20th century as a real pioneer in every sense of the word. For her "the chances for health propaganda were myriad. She could preach care of the teeth, ventilation of homes and schools, wholesome diet—feeding the baby with vegetables instead of pork gravy and

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green apples." She learned to saddle and ride a horse, to prepare her meals over a camp-fire, and to carry her nurse's equipment in her saddle bag.

Elizabeth Fox, director of the service, said of her nurses, "They must have the souls of missionaries and the self-sacrifice of saints."

The author brings out very clearly the influence of the American Red Cross upon nursing education. In 1947 Mary Roberts, editor of the *American Journal of Nursing*, wrote to a nursing administrator, "In my opinion the American Red Cross Nursing Service was by far the most important single factor in helping the nursing profession to put a floor (minimum standards) under nursing in many states."

This is an excellent source book on all phases of the American Red Cross Nursing Service — home nursing, nurses' aides, public health nursing, and reports of the various special nursing activities.

One gets the feeling that the Red Cross Nursing Service's "essential enduring principle is an ideal of service to humanity in the spirit of science, the mitigation of suffering with the vision and disciplined skill of the professional."

A man had rather have a hundred lies told of him, than one truth which he does not wish should be told.—SAMUEL JOHNSON.

M.L.I.C. Nursing Service

Claire Bernier, on the nursing staff at Jonquière, Que., and *Madeleine De Santis* of the Montreal staff, have been granted scholarships by the Metropolitan Life Insurance Co. to attend the University of Montreal School of Public Health Nursing. *Marie R. Boulanger* has been transferred from Drummondville to Montreal, *Marianne (Laframboise) Valin* from Chicoutimi to Jonquière. *Delisca Martineau*, of the Montreal staff, has resigned to accept another position.

British Columbia

The following are staff changes in the Division of Public Health Nursing, Department of Health and Welfare:

Appointments—*Shirley Bradford* (Montreal Gen. Hosp. and McGill University public health course) and *Catherine Byron* (St. Mary's Hosp., Timmins, Ont., and Univer-

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or by telephoning
No. 3-7341-Branch 230.

sity of Toronto) to Cariboo health unit, Prince George; *Elaine Delisle* and *Frances Neighbor* (Vancouver Gen. Hosp. and B.A.Sc., University of British Columbia) to Prince Rupert; *Lavinia Crane* (V.G.H. and B.A.Sc., U.B.C.) to Howe Sound public health nursing service at Squamish; *Helen MacAleese* (Addenbrookes Hosp., Cambridge, Eng., and University of Glasgow public health course) to Saanich and South Vancouver Is. health unit; *Agnes Macartney* (Saskatoon City Hosp. and U. of T. cert. course) and *Emily Nelson* (V.G.H. and B.A. and B.A.Sc., U.B.C.) to Upper Fraser Valley health unit at Chilliwack; *Mary Kartner* (St. Paul's Hosp., Vancouver), *Dorothy (Tate) Slaughter* (V.G.H.; B.A.Sc., U.B.C.; M.A., Teachers College, Columbia University) and *Greta Ward* (V.G.H.; B.A.Sc., U.B.C.) to Surrey; *Catherine MacKinnon* (Royal Victoria Hosp., Montreal, and B.N., McGill University) to East Kootenay health unit at Kimberley; *Margaret French* (Royal Columbian Hosp., New Westminster) to Matsqui-Sumas-Abbotsford public health service; *Joan Madden* (St. Paul's Hosp., Vancouver) to Kamloops; *Irene Rae* (V.G.H.) to Peace River health unit at Dawson Creek; *Margaret Goble* (V.G.H. and B.A.Sc., U.B.C.) to West Kootenay health unit at Trail; *Ann Purdie* (Calgary Gen. Hosp. and U.B.C. public health course) to Powell River service of Upper Is. health unit; *Frances Vernon* (R.C.H., New Westminster, and U.B.C. public health course) to Central Vancouver Is. health unit in Alberni area; *Muriel Treece* (V.G.H. and McGill University public health course) to Delta public health nursing service.

Transfers—*Marion Boyd* (St. Paul's Hosp., Vancouver, and U.B.C. public health course) from Ashcroft to Grand Forks to open new public health nursing district which will be part of West Kootenay health unit; *Fern Primeau* as senior nurse in Kamloops to Division of Tuberculosis Control, Vancouver; *Freda Hilton* as senior public health nurse, Prince Rupert, to Division of V.D. Control where she will be a member of the epidemiological staff; *Anna Spence* from Surrey to Prince Rupert to be senior nurse at this unit; *Lorraine Carruthers* from Howe Sound public health nursing service to Kamloops to be senior nurse in this district; *Gwen Farquharson* from Kimberley to Central Vancouver Is. health unit at Duncan; *Shirley Main* from Prince Rupert to Kimberley; *Margaret Steeves* from Prince Rupert to Dawson Creek; *Phyllis*

Dangerfield from Ladner to Simon Fraser health unit at Coquitlam; *Frances Hewgill* from Coquitlam to Windermere-Golden public health nursing district at Invermere; *Betsy Quayle* from Kamloops to Central Vancouver Is. health unit at Qualicum; *Sybil MacFarlane* from South Okanagan Valley health unit at Kelowna to Kamloops.

Leaves of Absence—*Isabel Anderson* from Peace River health unit and *Ada O'Brien* from Abbotsford to attend McGill University; *Mae Conn* from Alberni, *Audrey Damgaard* and *Maxine Bolton* from Surrey, *Hazel Fulmore* from South Okanagan health unit at Oliver, *Aldred Ker* from Prince George, *Betty Pullen* from Port Alberni — all to attend U.B.C.

Resignations—*Muriel Scott* from Division of V.D. Control to accept a position with WHO at Rangoon, Burma; *Jeannine Coupal* from Langley to join the Metropolitan Health Committee, Vancouver; *Hazel Provins* from Surrey, *Ann Olson* from Chilliwack, *Eda Edwards* from Prince Rupert health unit at Terrace, *Norma Tucker* from Alberni — all to be married; *Virginia Cline* from Qualicum to return to Ontario; *Doris (Barish) Gerber* from epidemiological staff, Division of V.D. Control, to live in Los Angeles; *Dorothy Dando* from Gibsons; *Elizabeth Ferrie* from Kamloops; *Pauline (Pearson) Penny* from Chilliwack; *Lydia Boss* from North Okanagan health unit at Armstrong; *Jane Withers* from Central Vancouver Is. health unit; *Sheena Smith* and *Olive Johnson* from Saanich and South Vancouver Is. health unit.

Vancouver

The following are staff changes in the Metropolitan Health Committee, Vancouver:

Appointments: *Caroline Harvie* and *Jessie MacCarthy* (Vancouver Gen. Hosp. and B.A.Sc., University of British Columbia); *Catherine Barrell* (Hamilton Gen. Hosp. and University of Toronto public health course); *Jeannine Coupal* (Ottawa Gen. Hosp.; McGill University p.h.n. course; McGill administration and supervision course); *Florence Eberts* (Winnipeg Gen. Hosp. and U.B.C. p.h.n. course); *Dorothy Fyffe* (Children's Hosp., Winnipeg, and U.B.C. p.h.n. course); *Mrs. Florence Higgins* (W.G.H. and U. of T. p.h.n. course); *Thelma Johnston* (St. Joseph's

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Re-appointments: *Jennie Hocking* after a year with the Division of Tuberculosis Control; *Elizabeth Leighton* who obtained her B.N. degree from McGill; *Marjorie McLaughlin* from a year's exchange with the B.C. Dept. of Health and Welfare; *Eva Williamson* who obtained her Master's degree from Teachers College, Columbia University.

Leaves of Absence: *Claire Lambe* to study at Teachers College; *Lara Thordarson* to study at U.B.C. School of Social Work.

Resignations: *Mmes Helen Coleman, Dorothy Donaldson, Anita Wong* to return to home duties; *Beverley Chalmers, Zoe Chang, Margaret Goble, E. Hayden, Evelyn Hood, Edith Linney, Marion Macdonell, Geraldine McIntyre, Sheila Ogilvie, Mrs. Nell Cody.*

News Notes

ALBERTA

JASPER

At a recent meeting of Edith Cavell Chapter, held at the home of Mrs. Bruce, 13 members were present. The nurses cooperated in assisting at the tuberculosis x-ray clinic held in October. Mrs. Recknagle has replaced Miss Scott, who has resigned, as secretary.

BRITISH COLUMBIA

CHILLIWACK

Mrs. M. Johnston presided at the first meeting of the season of Chilliwack Chapter. A report on the progress of the chapter's "adopted" child in England was given. It was also learned that Dolores Godette, winner of the chapter's $100 bursary, has commenced her training at Royal Columbian Hospital, New Westminster. Members were in favor of purchasing ten sheets of aluminum towards the recreation centre. Mrs. E. Bradleish was the winner of the evening's raffle.

The guest speaker was Carrie Kent of the Social Welfare who gave a talk on her Bermuda journey. Miss Kent was thanked by Mrs. B. M. Barwell and refreshments were enjoyed.

Port Alberni

A good attendance was evident at the first fall meeting of Alberni Valley Chapter. The resignation of H. Laycock was accepted with much regret. A vote of thanks for her untiring work as president was extended to her and she was wished much happiness and success in her new position at the Vancouver General Hospital.

A report of the R.N.A.B.C. annual meeting was given by A. Patterson. Mrs. Ed Price has taken over the Red Cross cupboard in Port Alberni. At the close of business, Mr. Rosso showed many beautiful slides he had taken of Vancouver Island and the Rockies.

Any new nurse in the district will be made welcome at the monthly meetings.

Trail

Two guest speakers were present at a meeting of Trail Chapter. Dr. W. S. Huckvale spoke on "Civil Defence Planning and ABC Warfare" with particular reference to the part played by nurses. Mr. L. M. Delong, president, Trail-Tadanac Hospital Board, reported on the proposed 150-bed hospital for the city of Trail and district, requesting the cooperation of the nurses in assisting to promote this project.

Victoria

Under the distinguished patronage of Lieut. Gov. and Mrs. C. Wallace, Premier and Mrs. Byron Johnson, and Mayor and Mrs. Percy E. George, the première of the film "The Lady With the Lamp," starring Anna Neagle, was shown to a packed house at the Royal Theatre on September 26. A guard of honor, composed of 16 student nurses from the Royal Jubilee and St. Joseph's hospitals, was formed for the guests. Irene Morley, president of the Student Nurses' Association of St. Joseph's, presented Mrs. Wallace with a bouquet of roses on her arrival at the theatre.

Mary Smith, president of the S.N.A. at Royal Jubilee, introduced Alice Wright, R.N.A.B.C. executive secretary, who welcomed the distinguished guests on behalf of the association, outlining briefly the work being done by the Royal College of Nursing in London. The entire proceeds of the film's première, shown in Ottawa as well as Victoria, will be sent to the college. In the prologue, Lady Mountbatten tells of the purpose of the college, which offers post-graduate study to nurses from all parts of the Commonwealth. To illustrate this, pictures of nurses were thrown on the screen, each nurse telling her purpose in availing herself of post-graduate study. Pauline Woodward of Vancouver was among the nurses seen from India, Australia, Malay, and Samoa.

Prior to the première, the Victoria Chapter executive were hostesses at a dinner held at the Empress Hotel when the following were present: Miss Wright; A. Cavers, representing the Vancouver General Hospital Alumnae Association; E. Palliser, director of nursing, V.G.H.; B. McCann, public relations chair-

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man, R.N.A.B.C.; Miss Nordlund, St. Paul's Hospital alumnae, Vancouver.

Royal Jubilee Hospital

The hospital is sponsoring a series of lectures which have been arranged with the teaching staff of Victoria Normal School. This program has been planned for the post-graduate class, supervisors, and head nurses who may be interested in the R.J.H. teaching program.

The instructors and subject matter are as follows: H. O. English, principal of Normal School, Introduction to Teaching Techniques; H. C. Gilliland, Psychology of Instruction and Classroom Procedures; G. A. Brand, Scientific Methods in Teaching with Demonstrations and Visual Aids; H. E. Farquhar, Measurements of Progress.

MANITOBA

BRANDON

The following officers will serve for the Association of Graduate Nurses during the coming months: President, Mrs. G. Hotson; vice-presidents, Mrs. D. Hatch, A. Coulter; secretary, L. Arnott; treasurer, Mrs. R. Catley. Committee conveners: Scholarship, E. Cranna; social, A. Chisholm; cancer, Mrs. D. L. Johnson. Representatives to: Press, L. Booth; *The Canadian Nurse*, B. Daniels.

P. Beecher, a graduate of Winnipeg General Hospital, has joined the staff of the Mental Hospital as instructor. Hope Toewes has returned to the staff after attending the McGill School for Graduate Nurses.

Winnipeg General Hospital

Mr. A. J. Bain, general secretary of the Zenana Bible and Medical Mission Society, was guest speaker at the October meeting of the alumnae association. His talk, illustrated by slides, told of the work of the society in India. The W.G.H. alumnae helps to finance the training of a native nurse in one of the mission hospitals. The alumnae's program for the coming months was outlined and it was decided that the archives of the association should be written and published within the next two years.

Helena Reimer, formerly assistant to the superintendent of nurses, has joined WHO.

NEW BRUNSWICK

MONCTON

Nurses' Hospital Aid

Recent well attended meetings were held at the Moncton Hospital, presided over by Mmes J. Pettet and J. Morrell. Reports were received from Mrs. M. Robinson on the fracture frame and Mmes B. Allen and G. Mayhew on the "Rolling Dollar." Mrs. M. Buchanan had the Dollar for October. Mrs. Mayhew, convener for the cooking sale, gave an account of this highly successful affair. Mystery Boxes were won by Mmes K. Carroll and G. Shaw. A committee, composed of Mmes Allen, Morrell, and Shaw, was

appointed to look into projects for the raising of funds.

New members welcomed to the meetings were Mmes K. Lamb, Nedelac, Candy, and Cousins.

SAINT JOHN

F. Saunders presided over a recent meeting of Saint John Chapter when the constitution and by-laws of the chapter, presented by M. Myers, were discussed and accepted. The report of S. Hartley, as delegate to the 35th annual convention of the N.B.A.R.N., was read. J. E. Lawson's resignation as publicity convener was received with regret. Miss Lawson will serve with the R.C.A.F.

Lancaster Hospital

At a regular meeting of the L.H. Nurses' Association it was decided to hold a Pound Party for overseas boxes. M. E. Anderson's report as delegate to the N.B.A.R.N. annual meeting was read.

ST. STEPHEN

Fourteen members were present at the annual meeting of St. Stephen Chapter held at the home of Mrs. B. Berry. The following officers will serve during the coming months: President, Mrs. C. Parks; vice-presidents, A. Mark, Mrs. R. Higgins; recording and corresponding secretaries, C. Boyd, Mrs. W. McWha; treasurer, Mrs. C. Anderson. Committee conveners: Entertainment, D. Parsons; ways and means, Mrs. R. Bartlett; refreshments, D. Ross; visiting, Mrs. L. O'Brien; nominating, A. Mark.

ONTARIO

DISTRICT 4

ST. CATHARINES

The following officers were elected by the Mack Training School Alumnae Association, General Hospital, to serve for the coming months: Honorary presidents, M. Hughes, C. Lymburner, E. Bell Rogers; president, Emily Purton; vice-presidents, M. Foran, B. Brown; secretary, J. Maclean; treasurer, F. McArter; social convener, E. Ettling; program, Mrs. F. Swayze.

A recent meeting took the form of a pot-luck supper and a shower for the contemplated bazaar.

DISTRICT 5

TORONTO

St. Michael's Hospital

Everyone here is still recalling happily the long week-end of October the sixth which not only saw the reunion of many of St. Michael's graduates but also marked the days of the centenary celebration of the Sisters of St. Joseph. Out of the past came tales of the hospital's early days, following the arrival here of a group of sisters from St. Louis, the cradle of the congregation in America.

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Present, to join in the celebrations, was Annie Chrysler Hilliker of Simcoe, Ont., who graduated in 1894 and is the only surviving member of that first class.

The nurses enjoyed showing the visitors the A south wing with its well equipped and modern new departments. Saturday afternoon tea was served in the hospital assembly hall as graduates exchanged news and greetings from all over Canada and the U.S.A. Reluctant farewells were made on Monday evening when the three days of celebration were over.

District 10

Port Arthur

Edith Fenton, public relations secretary for the R.N.A.O., addressed a fall meeting of District 10 when she reviewed the association's family tree from its infancy up to the present. Nurse legislation was expected to come into effect early next year. She also stressed the importance of nurses becoming members of their professional organization. A. B. Hunter thanked the speaker.

Mrs. D. R. Easton, chairman, who presided, reported on a board of directors meeting in Toronto. Mrs. R. Cunningham replaces Miss Sisson as convener of the public health committee. K. Feisel, former councillor, is now residing in Montreal where she is attending the McGill School for Graduate Nurses. Civil defence plans in connection with the nursing profession were discussed.

Tea was served by B. Stock, superintendent of nurses at Thunder Bay Sanatorium, scene of the meeting, assisted by K. Stock, P. Postans, E. Stark, Miss McLeod, and Mmes O. White and N. Cameron, members of the nursing staff.

While at the Lakehead, Miss Fenton also addressed groups of student nurses and was entertained at luncheon by members of the district executive. Dryden, Kenora, and Fort Frances were to be visited in the near future.

QUEBEC

Montreal

General Hospital

Something new! Christmas cards, bearing the M.G.H. crest, are available through the Alumnae Association in aid of the Norah Livingston Fund. Apply to *Miss Mabel Shannon, Nurses' Home, General Hospital, Dorchester St. E., Montreal 18.*

The School for Nurses was represented at the Chalet luncheon in honor of the Royal Couple by H. Dayman and L. Munro of the Western Division and B. Chalmers of the Central Division. J. Anderson represented the student nurses.

J. Watling, P. Smith MacGregor, and L. Ashbourne have resigned from the Western Division to be married. C. Graham and M. MacGregor have joined the hospital staff at Nababeep, Cape Province, South Africa.

Royal Victoria Hospital

The alumnae association was fortunate to have Capt. "X" speak on communistic activities at a recent meeting. Grace Moffat has resigned after many years' service as secretary-treasurer of the association and is succeeded by Mrs. L. Fetherstonhaugh. There is an appeal for new interest from all members. The Staff Nurses' Association has resumed activities for the 1951-52 season.

E. Turner has replaced Miss Eves as head nurse, Ward M, with M. O'Reilly as assistant.

St. Mary's Hospital

The School of Nursing Alumnae Association concluded another successful year last June and look forward to the coming months with anticipation. The annual Communion Breakfast and card party were two well attended events. The Mount Royal Hotel was the scene of the graduation dinner.

The following members are now on the executive: President, M. Harford; vice-president, Mrs. G. Barley; recording and corresponding secretaries, K. Murphy, E. O'Connor; treasurer, M. Smith; hospital benefits, K. Brady; visiting, E. O'Hare; social committee, R. Wood, Miss Mask; *The Canadian Nurse* and press representative, Mrs. J. J. Cosgrove.

SASKATCHEWAN

MOOSE JAW

Helen Penhale, director of the University of Alberta School of Nursing, was guest speaker at a meeting of the local chapter in October. A large audience heard a thought-provoking address on "Trends and Developments in Nursing."

SASKATOON

City Hospital

First aid classes, conducted by Mr. A. Batten of the Red Cross, are being held for registered nurses at the hospital. About 60 nurses are participating. A large number of staff members are attending classes at the university given by H. Keeler on ward administration, teaching and supervision. M. D. Russell, clinical instructor, attended the Saskatchewan Hospital Association convention in Regina.

Mrs. J. (Chisholm) Tait has been admitted as a Serving Sister of the Order of St. John, sanctioned by His Majesty The King. Mrs. Tait has been an active member of the brigade since 1914.

New staff members include Misses Simes, George, Pyne, Swanson, and Solvey, graduates of the Winnipeg General Hospital; Mrs. (Anderson) Stevens and Miss Rempel, 1951 S.C.H. graduates.

St. Paul's Hospital

Dr. Selinger gave a helpful course on mental hygiene for the graduate staff of the school.

Saskatoon Sanatorium

New staff members include: M. (Dean) Cressey, R. (Brown) Gritten, E. (Bennett) Hanson, F. Merinsky, B. (Fast) Schmidt, L. (Fast) Schmidt. A. Rempel and J. Stubbins have resigned, the latter to go to British Columbia. L. Keating-Fisher is taking public health at the McGill School for Graduate Nurses and I. Hamilton is enrolled in clinical supervision in O.R. at University of Toronto.

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WHEN baby is teething, fretful, suffering from constipation, colic or other minor upsets . . . experienced nurses know that Steedman's Powders bring prompt relief. Safe, gentle, easy to give—used the world over for 100 years. Eight out of 10 druggists recommend Steedman's, too . . . the fastest-selling product of its kind in Canada.

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For Teething Babies

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Offers to qualified *Registered Graduate Nurses*, post-graduate courses in:

(1). ***Operating Room Technique and Management*** —6 months.

(2). ***Obstetrical Nursing***—4 months.

For information apply to:

Director of Nursing
General Hospital
Vancouver 9, B.C.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Supt. for 42-bed hospital by Dec. 15. Apply, stating qualifications, experience & salary expected with full maintenance, to F. H. Bell, Sec. of Board, St. Andrews Hospital, Midland, Ont.

Matron for brand new 30-bed hospital. Salary: $225 per mo. plus full maintenance. 3 wks. vacation with pay. 48-hr. wk. Statutory holidays. New nurses' home. Town situated on 2 highways & 2 railways. 10 miles from summer resort. Apply Sec.-Treas., Union Hospital, Balcarres, Sask.

Health Supervisor with Public Health certificate. Also **Supervisor** with Teaching & Supervision certificate. Salary: $240 with annual increments. 44-hr. wk. 11 statutory holidays. 28 days vacation after 1 yr. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Graduate Nurses for 175-bed Tuberculosis Sanatorium near Prince Rupert, B.C. Salary for General Duty, $225 per mo. plus yearly increases. Room, board, laundry charged at $30 per mo. Applications from nurses with supervisory experience in tuberculosis work will be considered for Charge Nurse positions at higher rates. Transportation refunded on promise of 1 yr. service. Apply airmail, giving full details of experience, Matron, Miller Bay Indian Hospital, Box 1248, Prince Rupert, B.C.

General Duty Nurses. Basic monthly salary: $150 plus full maintenance. Also **Operating Room Supervisor** for well equipped 70-bed hospital. All graduate staff. Apply Supt. of Nurses, Douglas Memorial Hospital, Fort Erie, Ont. (10 min. from downtown Buffalo).

General Duty Nurses for Trail-Tadanac Hospital, Trail, B.C. Gross salary: $200 per mo. For full particulars apply Administrator, Miss Vera B. Eidt.

Supt. of Nurses for 74-bed General Hospital. Well qualified person required. Salary open. Apply, stating qualifications, experience & references, Administrator, General Hospital, Portage la Prairie, Man.

Asst. Dietitian (qualified) for 225-bed hospital. Apply Chief Dietitian, Moncton Hospital, Moncton, N.B.

Graduate Nurses (2) for General Duty immediately. Salary: $200 with annual increment of $5.00. Full maintenance, $40. 44-hr. wk. 28 days holiday after 1 yr. service. Sick leave, 1½ days per mo. Fare advanced if required. Apply Matron, Slocan Community Hospital, New Denver, B.C.

Registered Nurse qualified to teach **Tuberculosis Nursing** at Ongwanada Sanatorium, Kingston, Ont. For full particulars apply to Miss Vera J. Manders, Matron.

General Duty Nurses (2) immediately for Skidegate Inlet General Hospital of the United Church of Canada, Queen Charlotte City, Queen Charlotte Islands, B.C. Salary: $200 per mo. less $30 maintenance. $10 annual increment. 1 mo. vacation with pay after 1 yr. Transportation allowance up to $65 paid after 6 mos. Return fare after 1 yr. Apply Sec.

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invites applications for **Administrative** and **Staff** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

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For further particulars apply:

National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ontario.

Staff Nurses—all Depts. Optional—44- or 40-hr. wk. in all depts. Remuneration accordingly. 8-hr. day. $11, day duty; $12 per day, afternoon or night duty. 25 miles north of Detroit. Apply Director of Nurses, St. Joseph Hospital, Mt. Clemens, Michigan.

Registered Nurses for Sunnybrook & Westminster Hospitals, Toronto & London, Ontario. Salary: $2,160-2,772 per annum. Information & application forms available at Post Offices. The latter should be filed with the Civil Service Commission of Canada, 1200 Bay St., Toronto 5, Ont., as soon as possible.

Registered Nurses for General Duty for small General Hospital. Salary: $125 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

General Duty Nurses for modern, well-equipped hospital in picturesque Lakehead. 45-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $185 less $20 for meals. A further $25 charged if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. **Pediatric Supervisor** (teaching & administrative). $225. **Asst. Night Supervisor.** Rotating 3-11, 11-7. $225-235 depending on qualifications. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

Vancouver General Hospital requires: **General Staff Nurses**—Salary: $185-215 plus afternoon & night shift differential. Perquisites: 44-hr. wk.; 11 statutory holidays; 28 days vacation; 1½ days per mo. cumulative sick leave; Pension Plan (if under 35). Apply Director of Nursing, General Hospital, Vancouver 9, B.C.

Nursing Arts Instructor for General Hospital, Hamilton, Ont. Nurse experienced in bedside nursing & ward administration & with post-graduate course in Teaching & Supervision required. Initial gross salary bi-weekly: $99 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites—vacation, illness, pension, etc.—& further information apply Supt. of Nurses.

Graduate Floor Duty Nurses for Mt. Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $79 plus Cost of Living Bonus. For other perquisites & further information write Supt.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $79 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites & further information write C. E. Brewster, Supt. of Nurses.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $125 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end each mo. 1 mo. annual vacation. 14 days sick leave. Apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $175-213 plus $20 C.O.L. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Public Health Nurse (qualified). Salary according to experience. Car provided or car allowance. Desirable position close to Toronto. Apply Medical Officer of Health, York County Health Unit, Newmarket, Ont.

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has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

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For further information write to:

Chief Superintendent,
Victorian Order of Nurses for Canada,
193 Sparks Street,
Ottawa 4, Ont.

Instructor of Nursing & Clinical Supervisor. Apply Director of Nursing, Victoria Public Hospital, Fredericton, N.B.

Nursing Arts Instructor & General Duty Nurses for 200-bed hospital. Salaries $195 & $175 plus Cost of Living Bonuses, respectively. 8-hr. day, 88-hr. fortnight. Statutory holidays. Sick time. 4 wks. annual vacation. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, B.C.

Asst. Supervisor for Operating Room of 450-bed General Hospital. Apply, stating qualifications & salary expected, Director of Nursing, General Hospital, Saint John, N.B.

Science Instructor (1) **& Nursing Arts Instructor** (1) for new hospital to be opened 1952. Salaries open. Apply Supt., Charlotte County Hospital, St. Stephen, N.B.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

Matron for 18-bed hospital. Salary: $250 less maintenance. **General Duty Nurses** for southern interior B.C. hospital. Salary: $200 less maintenance plus $5.00 night duty. Annual increment. 44-hr. wk. 3 rotating shifts. 4 wks. holiday with full salary. Fare up to $50 refunded after 1 yr. service. **Operating Room Nurse.** Salary: $210. Balance of terms of employment as above. Apply Creston Valley Hospital Association, Box 30, Creston, B.C.

Registered Nurses for General Staff for Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, Smiths Falls, St. Thomas, Toronto, Whitby, Woodstock. Gross salary: $2,260 per annum with maximum salary of $2,660, less perquisites ($26.50 for room, board, laundry). Cumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 44-hr. wk. Apply Supt. of Nurses at above hospitals.

General Staff Nurses for 60-bed Pediatric-Orthopedic Hospital. For information apply Director, Shriners' Hospitals for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

Laboratory Technician. Gross salary: $170 per mo. 177-bed hospital. For full particulars apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Operating Room Supervisor. Salary: $210 per mo. gross. **General Duty Nurses.** Salary: $165-175 per mo. gross depending on experience. **Night Supervisor.** Salary: $210 per mo. gross. 44-hr. wk. 2½ days holiday per mo. Half day on statutory holidays. 1½ days per mo. sick time cumulative to 30 days. Charge of $30 per mo. made for board & room. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Charge Nurse for Admitting Dept. of Children's Hospital, 250 West 59th Ave., Vancouver 15, B.C., by Jan. 1952. Special qualifications or previous experience in out-patient clinics & admitting office routine necessary. Apply Director of Nursing.

General Duty Nurses. Salary: $163.40 (one sixty-three dollars & forty cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Staff Nurses, eligible for registration in Michigan, for all services in modern 200-bed hospital. Salary: $226 per mo. for 40-hr. wk. 6 mos. increase. $10 extra for 3-11 & 11-7 duty. 7 paid holidays. 2 wks. vacation & 12 days sick leave per yr. Cafeteria meal service. Laundry furnished. Apply Supt. of Nurses, General Hospital, Pontiac 18, Michigan.

UNIVERSITY OF WESTERN ONTARIO SCHOOL OF NURSING

Offers the following programmes:

(1) A five-year programme leading to degree, *Bachelor of Science in Nursing.*

(2) One academic year of study and experience leading to Certificate in *Public Health Nursing.*

(3) One academic year of study and experience leading to Certificate in *Teaching and Supervision in Schools of Nursing.*

(4) Three months of study and experience in *Psychiatric Nursing.*

For further information write to:

The Dean, School of Nursing, University of Western Ontario, London, Ont.

Public Health Nurses for Province of Alberta. Rural service. Emergency treatment, preventive & maternity program. Furnished cottage, fuel, water supplied. Salary schedule: $2,400-3,000. Sick leave, annual vacation, pension. Apply Director, Nursing Division, Dept. of Public Health, Edmonton, Alta.

Matron & General Duty Nurse (2 nurses with Missionary interest) for 25-bed United Church Hospital on B.C. Coast. Urgent. Excellent opportunity for nurses wishing to serve their church. Majority of work with native Indians. Write for particulars Medical Supt., General Hospital, Bella Coola, B.C.

Registered Nurses (2) for General Duty in new modern 20-bed hospital. Salary: $160 per mo. & full maintenance. Duties to commence Jan. 1. Apply P. J. Rasmussen, Sec., Union Hospital, Climax, Sask.

Registered Nurses for General Duty. New approved 25-bed hospital. Salary: $250. 5-day-40-hr. wk. 6 holidays per yr. 2 wks. vacation with pay. Liberal policies. Apply Administrator, Del Puerto Hospital, Patterson, California.

General Duty Nurses for Pediatrics; General, Surgical & Medical Nursing for permanent positions. For information & personnel policies write Director of Nursing, Victoria Hospital, London, Ont.

Registered Nurses for General Duty for 35-bed General Hospital, 50 miles from Toronto. Gross salary: $178 per mo. 48-hr. wk., rotating shifts. 3 wks. annual vacation. 8 statutory holidays. For particulars apply Supt., Lord Dufferin Hospital, Orangeville, Ont.

General Duty Nurses for Queens General Hospital, Liverpool, Nova Scotia. New hospital. Ideal living conditions. 8-hr. day. Blue Cross available. Apply, stating qualifications & experience, to Supt.

Graduate Nurses for completely modern West Coast hospital. Salary: $210 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. **Working Supervisor for Obstetrical Ward.** Salary to commence at $225 per mo. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

General Duty Nurses for 680-bed General Hospital with School of Nursing. Beginning salary: $255 with $10 additional for special services, p.m. & night shifts. $13 increase after 6 mos. $14 additional increase 1 yr. after 1st increase. 40-hr. wk. 11 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Full maintenance if desired at $45 per mo. Apply Director of Nursing Service, General Hospital, Fresno, California.

Registered or Graduate Nurses (2) for modern 20-bed hospital. Salary: $180 & $170 per mo. gross. Usual holiday time & sick leave. Apply E. W. Groshong, Sec.-Mgr., Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.

Registered Nurses for 60-bed General Hospital. Commencing salary: $150 per mo. plus full maintenance. 44-hr. wk. 3 wks. vacation per yr. & statutory holidays. Apply Supt., Public Hospital, Smiths Falls, Ont.

Supt. of Nurses by Feb. 1 for 150-bed General Hospital—75 student nurses. Gross salary commencing at $290 per mo. plus pension plan. 8-hr. day, 6-day wk. 1 mo. vacation annually. Apply, stating qualifications, experience & age, Administrator, General Hospital, Chatham, Ont.

Clinical Supervisor. Apply Miss C. MacCullie, Director of Nurses, General Hospital, Woodstock, Ont.

General Duty Nurses for small hospital. Salary—Registered Nurses, $160 per mo. plus full maintenance; others according to qualifications. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

General Duty Graduate Nurses for new, well equipped 60-bed acute General Hospital in heart of famous logging & fishing industries on B.C. coast. Salary: $185 per mo. less $25 for board, room, laundry. 4 wks. annual vacation plus 10 statutory holidays. Sick time. Fare advanced if desired. Apply Supt. of Nurses, St. George's Hospital, Alert Bay, B.C.

Registered or Graduate Nurse for new 7-bed hospital. Apply in writing, stating experience & salary expected, Miss Cora E. Barber, Matron, District Hospital, Cartwright, Man.

Registered Nurses (6) immediately for 30-bed hospital in Northwestern Ontario, the heart of a tourist's paradise. Duties to commence Jan. 1. Modern nurses' residence—single rooms. Salary: $160 per mo. plus full maintenance. Salaries subject to annual increase. 1 mo. vacation with pay after 1 yr. service. Successful applicants reimbursed rail fare on completion of 1 yr. service. Apply Supt., District General Hospital, Box 526, Dryden, Ont.

Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Clinical Instructor for Operating Room. 8-hr. day, 44-hr. wk. Apply Director of Nursing, Civic Hospital, Ottawa, Ont.

Matron & General Staff Nurse (rotating shift) immediately for 16-bed hospital. Salaries: $200 & $160 per mo. plus full maintenance. 1 mo. holiday after 1 yr. service. Separate residence. Apply L. Fetter, Sec., Union Hospital, Eastend, Sask.

Registered General Duty Nurses (2) for 18-bed hospital. Salary: $165 per mo. plus board & room. $5.00 bonus for night & evening shifts. 1 mo. holiday with pay after 1 yr. Pleasant working conditions in new hospital. Apply Sec.-Treas., Municipal Hospital, Rimbey, Alta.

Registered Nurse as Asst. Matron for 30-bed hospital. This is a new opening & members on staff are notified of position. Duties to commence Feb. 1. Salary: $175 plus full maintenance. Separate nurses' residence. 1 mo. holiday with pay after 1 yr. service. For further information write or phone Sec.-Mgr., Union Hospital, Hafford, Sask.

Here is an opportunity for a Registered Nurse to save up to $1,500 in 1 yr. through appointment as **Charge Nurse** or **Ward Supervisor** in a Tuberculosis Sanatorium. Responsible & interesting duties, including major surgical nursing. Up-to-date equipment, comfortable living quarters, group insurance. 44-hr. wk. 10 statutory holidays. Bonus of 2 wks. pay at end of 1 yr. or 4 wks. paid vacation if continuing in service. For full particulars apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Graduate Nurses for General Duty in modern well equipped 100-bed hospital. Minimum gross salary: $175 per mo. with increments of $5.00 every 6 mos. until maximum is reached. 8-hr. day, 6-day wk. Apply Supt., St. Mary's Hospital, Camrose, Alta.

Operating Room—General Staff Nurses. Gross monthly salary: $193.50 ($210.50 less perquisites, 2 meals & laundry, $25.50). 8-hr. day, 44-hr. wk. Apply Director of Nursing, Civic Hospital, Ottawa, Ont.

Registered Nurses for General Staff (2) in 21-bed hospital. Salary: $140 per mo. Room, board, uniform laundry provided. Rotating shifts. 48-hr. wk. Blue Cross Plan. 3 wks. holiday after 1 yr. service. Also **Nurses' Aide.** Apply Supt. of Nurses, General Hospital, Espanola, Ont.

Public Health Nurses for generalized program with Health Unit. Minimum salary: $2,200 with allowance for experience & annual increments of $120. Cumulative sick leave plan. Pension plan & Blue Cross Hospital Plan available if desired. Interest free loans available for purchasing car if necessary. Apply A. E. Thoms, M.D., Director, Leeds & Grenville Health Unit, Victoria Bldg., Brockville, Ont.

Registered Nurses with Public Health Training & experience, preferably generalized. Not over 35 yrs. of age. Initial salary: $2,700 with annual increment. Pension scheme available. Apply Director, Nursing Service, Ontario Society for Crippled Children, 112 College St., Toronto 2, Ont.

Matron & Registered Nurse immediately for Kyle-White Bear Union Hospital, Sask. New & modern up-to-date 8-bed hospital. Nurses' home separate bldg. 6 miles from Clear-

water Lake Summer Resort. Apply, stating qualifications, experience & salary expected, Wm. Lowe, Sec.-Treas. or phone R. H. Whalen, Kyle, Sask.

Registered Nurse immediately for Nursing Station at Loverna, Saskatchewan. Pleasant community in which to work. Salary: $185 per mo. less $20 for maintenance. 1 mo. vacation with pay. Transportation paid to point of duty. Apply to Saskatchewan Division, Canadian Red Cross Society, 2331 Victoria Ave., Regina, Sask.

Registered Nurses at once for 40-bed hospital situated in a pulp & paper industrial town on Pacific Coast. Numerous recreational facilities. Salary: $200 per mo. gross less $40 maintenance. 44-hr. wk. 10 statutory holidays. 1 mo. vacation after 1 yr. service. Fare from Vancouver refunded after 6 mos. service. Apply, with full particulars & references, Miss F. Gerwing, Supt. of Nurses, General Hospital, Ocean Falls, B.C.

Registered Nurses (**2**) immediately. Gross salary: $185 per mo.—$30 deducted for maintenance. $5.00 increase per annum for 4 yrs. 1 mo. holiday with pay after 1 yr. service. 3 wks. sick leave per yr. Apply Matron, Union Hospital, Rosetown, Sask.

Registered Nurses (**8**). Starting salary equivalent to Calif. State Nursing Ass'n standards. Comfortable modern nurses' home available—$10 per mo. After 1 yr. 23 vacation days. Cumulative sick leave. 11 holidays yearly. Rotation shift if desired. Vacancies all nursing services—Surgery Nurse & Obstetrical Nurse supervisory; Teaching Supervisor. Apply Director of Nurses, County General Hospital, Tulare, California.

Spurts in Population

In the United States the annual excess of births over deaths has averaged better than 15 per 1,000 population, which is above the level immediately following World War I, and about twice the rate during the depression decade of the 1930's.

The trend has been similar in Canada and New Zealand.

In France, where virtually no population gains had been made for a century, and where as recently as 1940-44 deaths exceeded births, the rate of natural increase has averaged better than 7 per 1,000 each year since 1946. In Ireland, which had been losing population for a century, the excess of births over deaths has been somewhat more than 8 per 1,000 during the past six years.

The Latin American countries as a group have had average population increases of more than 20 per 1,000, with Puerto Rico having an annual rate of close to 30 per 1,000 or double the rate of natural increase prior to 1930.

Exceptions to the major trend toward accelerated population increase are in England and Wales, Australia, and Scotland, and in a number of European countries, among them Germany, Italy, and Austria.

— *Metropolitan Information Service*

Your Sense of Smell

Women have a better sense of smell than men; brunettes better than blondes; redheads better than either. Fish smell better than any animals. These are a few discoveries made by researchers studying odors — and people. Other findings: some people are smell-blind, just as some are color-blind. The odor of magnolias will stimulate children's appetites. Sheets scented with jasmine or lilac are relaxing — aid sleep. Your sense of smell is 10 thousand times greater than your sense of taste.

— *Feature.*

Dear Friends . . .

A Very Blessed and Merry Christmas to you—one and all. This Christmas will be my first in my new home and I would love to hear from you.

Cordially . . .

Alta C. Walls

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Official Directory

Provincial Associations of Registered Nurses

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Alberta Association of Registered Nurses

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Medicine Hat District, No. 4, A.A.R.N.

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Red Deer District, No. 6, A.A.R.N.

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BRITISH COLUMBIA

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New Westminster Chapter, R.N.A.B.C.

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec, Incorporated February 14, 1920.

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A.A., Grace Hospital, Winnipeg

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A.A., Winnipeg General Hospital

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